Thesis

“Honour and interests”: medical ethics in Britain, and the work of the British Medical Association’s Central Ethical Committee, 1902 - 1939

submitted by

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Abstract:

Histories of medical ethics have neglected the early twentieth century, and concentrated on philosophical principles, codes, current concerns, or have described older ethical systems as etiquette, designed to enrich doctors. I have examined the Central Ethical Committee (CEC) of the BMA, an organisation then representing most practising doctors, and analysed medical ethics as a social historical phenomenon and aspect of medical professionalisation.

In 1902 the new BMA and CEC emerged from a medico-political crisis in which failures of solidarity were construed as ethical issues. The key members of the CEC were senior middle-ranking practitioners, but the organisation had strong links with the General Medical Council and the Medical Defence Union. The committee dealt largely with enquiries and disputes between doctors, but also formulated policy on medical ethics, considering all the issues prominent in the sparse contemporary literature. These issues have been examined in turn, along with the literature starting with Percival’s 1803 Code, and the behavioural strictures inherent in collegiate organisations. These issues were, solidarity in boycotting unsuitable appointments; the use of local ‘courts of honour’ to settle disputes; the etiquette and ethics of consultation; relationships with unqualified and unorthodox practitioners; advertising that both directly and indirectly involved doctors; relationships with medical businesses of all kinds; and confidentiality, particularly in courts of law. Abortion is discussed as an example of a moral question not then included in medical ethics per se.

This system aimed to uphold unwritten medical characteristics and traditions, to differentiate doctors from quacks and tradesmen, and to promote professional honour, as a means of defending medical interests. It defined the profession behaviourally, and created a ‘space’ in which medical excellence could flourish. Despite profound social and technological change medical ethics can still be construed as a moral adjudication of medical behaviour integral to defining the boundaries between profession, patients and society.
Acknowledgements

Christopher Lawrence, my tutor in 1987-88, did me two great favours, firstly by directing my interest in history of diet toward the specific example of Sir William Arbuthnot Lane, and secondly through his rigorous approach to the writing of history, some of which, I hope, has remained with me. He and Tilli Tansey sponsored my Research Fellowships in 1992-93 during which time I started some of the research on which this thesis is based. I must thank the Wellcome Trust for their support funding my research fellowships at the Wellcome Institute for the History of Medicine. In the periods of time between my years at the Wellcome Institute, during which I was a clinical student, and later working as a Junior Hospital Doctor and GP trainee, the personal and intellectual encouragement of Michael Neve has been indispensable.

Roy Porter encouraged me to examine the ethical material in the BMA archive thoroughly. Bill Bynum, who need not have taken me on as a student during his sabbatical, deserves unreserved thanks for the generosity with which he has made his time available to me, and for the pertinent advice he has always offered. My archival tasks would have been intolerable but for the help and support of Emily Naish, archivist at BMA House, and Lesley Hall and Julia Sheppard at the Wellcome Contemporary Medical Archives Centre. The Library staff at the Royal Society of Medicine also helped on many occasions, especially when I was lost in their basement stacks. Comments, criticism and support have over the years been welcome from many colleagues, but I should like to mention particularly some not already mentioned, they include: Anne Hardy, Mark Harrison, John Carson, Stephen Lock, J Stuart Horner, Rhodri Hayward, Chandak Sengoopta.

Lastly, I have come to discover why theses and books are so often dedicated to the partner of the author. My wife Jane has put up with this project, and the impact it has had on our home life, with great cheerfulness. And my son Angus, who has not the first clue what I have been doing up in our attic all this time, has, with his mother, provided the perfect antidote to the life of the scholar.

“In a book of this kind the accident of where and when the author was educated is bound to make a difference, both to the selection and the treatment of the material. ... It may be thought that in some cases too long has been spent on the details of a rather trivial argument, at the expense of a wider view of the whole subject. My defence would be that in such a subject as ethics, the details of the argument are all important. ... I have not, I hope had any preconceived idea of what ethics is.”

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Section I

The BMA Ethics Committees
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Chapter 1

The history and historiography of medical ethics

Introduction

This thesis will examine the deliberations, literature, judgements and ideas of British doctors concerned with medical ethics during the years before the Second World War. Most attention will be given to the work of a committee of the British Medical Association (BMA), the Central Ethical Committee (CEC), but I shall also examine the literature, and work of other organisations involved in medical conduct issues. The approach to this material has been that of a social historian of medicine, not that of a philosopher specialising in ethics. My concern has been to discover what doctors at this time meant by medical ethics, how they arrived at and justified their ethical structures and codes, and what this says about the medical profession and its relationship to contemporary society. This project has presented a number of challenges, which I shall set out, along with a brief history of the subject in this opening chapter.

Most of these challenges flow from the term “medical ethics” itself. The phrase has been in use since the turn of the nineteenth century, but has denoted a content that has changed slowly up until the 1940s, and very rapidly thereafter. Many writers in the twentieth century have concluded that this discourse was not “ethical” at all. Robert Baker noted that “historians have regularly perused the literature and ... found no ethics other than the [Hippocratic] Oath”. Even if this value judgement is resisted, earlier medical ethics were demonstrably different to those discussed and promoted today. Many writers have tended to ‘buy into’ a set of current ethical judgements when assessing those of the past, or have traced the discussion current ethical concerns back in time.

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1 Percival, Thomas, Medical Ethics; or a code of institutes and precepts adapted to the professional conduct of physicians and surgeons, Manchester, J Johnson and R Bickerstaff, 1803.
4 Good examples are found in the works cited in notes 8, 23 and 24.
This latter approach is an honourable and useful one, and illuminates much of the history of certain aspects of medicine and medical science, but it does not alone create a sound history of medical ethics. It would be fair to say that a thoroughgoing detailed history of medical ethics remains to be written, and that most scholars working in the area (including to an extent, myself) have come to the subject by way of other studies.

At the same time, it is not sufficient to simply focus on the content of texts, structures and discussions carrying the label "medical ethics" without asking whether these texts do or do not form part of a continuous historical or social phenomenon. This is particularly the case when dealing with the current century. The gap between Thomas Percival's *Medical Ethics* (1803) and the Nuremberg Code (1947) and Declaration of Geneva (1948) is only comfortable if the historian's gaze is kept firmly on one or other target. Whilst the time frame of this study has, to a certain extent, enclosed the last years of an *ancien régime* I have not felt it appropriate to dodge this issue. It is clear that by the mid-twentieth century two different streams of medical ethical ideas existed side by side. This is most apparent in the publication of the BMA's code of ethics in 1949 which immediately followed the Nuremberg and Geneva statements. The BMA's code was essentially a summation of the previous half-century's work, whilst the Nuremberg and Geneva codes contained a quite new agenda based on human rights.

The historian of medical ethics in the twentieth century is faced with a seemingly straightforward choice between a retrospective recategorisation of earlier medical ethics as "mere etiquette" with no ethical content, (a criticism with a long pedigree as it happens) or acceptance of a radical shift in content within the same semantic frame. The first approach is frankly ahistorical, and the second begs important questions as to whether the change in content constitutes an accident of labelling, or a profound shift in the way in which a fundamentally continuous social phenomenon has been played out.

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The approach I have adopted to this problem has been to broaden the concept of ethics away from philosophical principles towards a more sociological or anthropological analysis. I have framed medical ethics as a **discourse and adjudication of right and wrong behaviour in medicine**. Whilst it does not explain the “absence” of certain modern ethical concerns in the central canon of Pre-war medical ethics, it does allow its actual content to remain within a broad conception of ‘ethics’, and allows contextualisation to be more readily achieved. One problem of this approach is that it is very inclusive. Whilst this allows for the very important links between medical ethics, medical discipline and medico-legal problems to be explored, it has been hard to draw a consistent boundary around the subject matter. The last challenge, intimately related to these two, has been to make the best and most sensitive use of extremely rich archival materials.

**The history and histories of medical ethics**

Fragmentary evidence survives from antiquity of many rules governing the work of healers, and these include the Babylonian Code of Hammurabi (almost always mentioned in histories of the subject produced by figures involved in the BMA and the CEC), but also included Assyrian, Persian, ancient Indian and Chinese rules, laws and codes. Many of these were state laws and rules with religious sanctions drawn up by non-practitioners. It is striking therefore that one small local code, drawn up for a particular school of practitioners on the island of Kos had dominated the historiographical and more popular conceptions of the ancient roots of medical ethics. The Hippocratic Oath, almost certainly not written by “Hippocrates”, has survived to enjoy a twentieth century revival. Vivian Nutton has shown that although the Oath was not used in Europe until the Renaissance, and ascribes its survival and subsequent durability to the suitability of its “peculiar” injunctions about abortion, euthanasia and surgery to the Judeo-Christian-Muslim world. He also demonstrates that codification of the ideal conduct of physicians and surgeons could be achieved without recourse to the Oath in antiquity and the mediaeval period.

Wear, Geyer-Kordesch and French set out in their collected volume of 1993 to show that “a history of medical ethics does in fact exist and that medical ethics were a constant part of the history of medicine in the period between those often-cited ‘origins’ of medical ethics, the Hippocratic Oath.

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and Thomas Percival's Medical Ethics. Contributors to the volume discussed examples such as civic rules regulating physicians, and the duties implied on various parties by the payment of fees, the discussion of the rights and wrongs of fleeing cities afflicted by the plague, and the German medical jurisprudential responses to infanticide. Yet no overall consensus emerges from the volume as to how to frame medical ethics as a historical subject. What is demonstrated is that alongside codes of conduct, (usually framed by collegiate or civic organisations), and medical jurisprudence, (which developed particularly strongly on the Continent whilst remaining little discussed in Britain), doctors during the early modern period were also concerned with subjects such as competence, best choice of treatment and conflicting duties. This is unsurprising. It would be most remarkable if sets of physicians operating within cultures pervaded by Christianity had neither developed or discussed ideas relating to right and wrong action, nor developed mechanisms whereby groups of healers promoted their own status. Yet French, writing in this same volume, articulates perhaps the clearest historiographical statement I have come across, and it is from this statement that I have developed much of my approach to the history of the subject. He says:

The current interest in medical ethics is an interest in ethical problems. It might seem unproblematic that medical ethics have a history, and that these problems can be studied in the past. We might for example take the problem of abortion and look at it historically. But then we would find that there have been times and places in which abortion provided no ethical problems. Such a history would be the history of a practice, not of an ethical problem. In other words, modern medical ethics derives from the particular nature of modern medicine and the society in which it exists. So a history of medical ethics is a history of medicine and of society and of the problems that looked ethical to them, but not necessarily to us. Looked at in this way it soon becomes clear that ethics have a function, for the group that practices them, other than the internal, explicit injunctions that are normally seen as "ethical" in some abstract way. Most of the Hippocratic ethical works can be read as defences of the medicine of one group when threatened by another. ... Ethics comprise a system of rules that not only characterises the group but which in directing the behaviour of the group contributes to its success.

13 Garcia-Ballester, Luis, 'Medical Ethics in Transition in the Latin medicine of the Thirteenth and Fourteenth Centuries: new Perspectives on the Physician-Patient Relationship and the Doctor's Fee' in ibid., pp.38 - 59.
14 Grell, Peter Ole, 'Conflicting Duties, Plague and the obligations of early modern physicians towards patients and commonwealth in England the Netherlands', in ibid., pp 131 - 146.
16 French, Roger, 'The Medical Ethics of Gabriele de Zerbi' in ibid., p. 72.
The Enlightenment

In the eighteenth century a history of medical ethics can begin to draw on much more ‘comfortable’ sets of sources; and much attention has focussed on a literature discussing doctor’s duties and conduct situated in a wider discussion of civilised behaviour which drew on philosophical discussions. As Porter has demonstrated,\(^\text{17}\) the works of John Gregory and John Percival, which have been characterised as seminal in the history of British medical ethics, both drew on generic ideals of gentlemanly duty, Christianity and civility set out by Thomas Gisbourne.\(^\text{18}\) The roots of John Gregory’s work have also been traced in Humean philosophy,\(^\text{19}\) which stressed the importance of individual moral sensibility and sympathy.\(^\text{20}\)

In many senses Thomas Percival’s *Medical ethics* remains a crucial document in the history of medical ethics, with its demonstrable links into the world of Enlightenment philosophy and subsequent influence, particularly in America. The ethical codes of the American Medical Association were based directly on Percival for nearly a century after they were drafted in the 1840s. Robert Forbes,\(^\text{21}\) a British doctor closely involved in the organisations with which this thesis shall deal, stated in 1955 that *Medical ethics* was “a prominent landmark in the progress and evolution of medical ethics ... no later work has modified in any material degree the precepts and practice defined by Percival”.\(^\text{22}\) Unsurprisingly Percival has also been the focus of attacks on the medical profession and its ethics. Chauncey Leake published an edition in 1927 mainly as a vehicle for his condemnation of the American medical ethics flowing from it. For Leake, such “ethics” were simply “etiquette” designed to protect the material and social status of doctors, masquerading as principles. This argument, albeit in the more sophisticated clothing of sociological critique, was taken up by writers like Berlant,\(^\text{23}\) Friedson and Waddington\(^\text{24}\) in the 1970s. For them these

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\(^\text{18}\) Gisbourne, Thomas, *An enquiry into the Duties of Men in the Higher and Middle Classes of Society in Great Britian, Resulting from their respective Stations, Professions and Employments*, 1794.


\(^\text{21}\) Forbes was involved in the CEC, the GMC and the MDU, see biography, p. 325.


traditional medical ethics were monopolistic "closure" mechanisms. A quote from Friedson summarises this view,

Much of what has been called "ethics", and certainly the commonly understood rules of etiquette, is designed to prevent "unfair" internal competition and preserve comparative equality of opportunity in the medical marketplace at the same time as it preserves an impeccable front of silence to the outside world.\textsuperscript{25}

But as Baker has pointed out, these writers, (whom he identifies as the "revisionist school") particularly those writing in the USA were attacking Percival as part of an attack on the AMA.

Percival has been 'rehabilitated' by the careful work of John Pickstone, who, like anyone who troubles to read the whole of Percival's text, rather than just the first chapter, has found that these scholars caricatured the content of his work. Pickstone characterises Percival as standing for a set of Enlightenment beliefs within which doctors could take their place in a unified local ruling elite, and points out that he wrote his text following a highly politically charged dispute over the running and control of Manchester's excellent Infirmary in 1794. His book was partly a defence of a status quo that was threatened by such contention, and set rules designed to prevent it.\textsuperscript{26} However, having produced these basic rules (Chapter I of \textit{Medical Ethics}), Percival then went about circulating them, collecting comments on them and other examples of local rules from "a galaxy of medical and literary friends". Eventually, after adding chapters on conduct outside the Hospital setting, and most interestingly on "duties ... which require a knowledge of the law" (Chapter IV), he published the whole text 9 years later, shortly before his death.

As Baker notes,\textsuperscript{27} and as Percival himself clearly stated, the choice of the term "medical ethics" was contentious and he had originally planned to entitle his work, "Medical Jurisprudence". However, he had been persuaded that the rules and ideas he set out were moral rather than legal in nature.\textsuperscript{28} Percival was propounding a mechanism in which personal honour and virtue was allied to, dependant on and at times subordinated to collective adjudication, collaboration and honour. Many of the statements made by Percival will be examined in detail in the second section of this thesis.

\textsuperscript{26} Pickstone, John V, "Thomas Percival and the production of Medical Ethics", in Baker et al. (eds) \textit{Medical Morality, Vol I}, 1993, 161 - 178.
\textsuperscript{27} Baker, Robert, "Deciphering Percival’s Code", in \textit{ibid.}, 179 - 211.
\textsuperscript{28} Percival, Thomas, \textit{Medical Ethics}, 1803, (in Leake, \textit{Percival’s Medical Ethics}, 1927, p. 66.)
The nineteenth and twentieth centuries

A second volume edited by Baker examined the influence of Percival on American medical ethics, and included a series of papers on British medical ethics. We do not need to be concerned with the first task of this volume here, but the contributions on Britain and Baker’s conclusions on them need examining. The volume contains the first edition of Jukes de Styrap’s *Code of medical ethics* (1878) with an introduction written by Peter Bartrip. This work is considered in detail in chapter 5. Bartrip also contributed a chapter on the challenges to the BMA’s campaign against proprietary medicines in the 1900s and 1910s, which was criticised as hypocritical because doctors used these remedies and because the *BMJ* continued to carry advertising for them. However this paper did not draw on any deliberations by the CEC, and their relationship to the controversy, some of which will be examined in chapter 10. It is striking that Baker did not attempt to bring this chapter into his overall synthesis of the volume. Two other papers are used by Baker to assert that there can be “a cohesive story about how the Enlightenment medical ethics that Gregory and Percival bequeathed to the English-speaking world came to codified as medical ethics in America and as medical jurisprudence in Britain.” The two papers in question are by Anne Crowther and Russell Smith, and to be fair, neither makes such strong claims for itself.

Crowther notes that if medical ethics was taught at all to medical students in the nineteenth century it was taught as part of Medical Jurisprudence (that is medico-legal) lecture courses, and was thus “a marginal part of a marginal subject”. However her analysis, which raises a number of interesting points about the conservativism of the Medical Jurisprudence literature, is based very largely on this literature. The “ethical issues” followed are those that are of current concern. Russell Smith, an academic lawyer who has published on the GMC, undertook an exhaustive case by case analysis of the disciplinary hearings of the Council between 1858 and 1984. Smith’s interest in the GMC is essentially to ascertain the extent to which the modern Council conforms to current standards of procedural justice, and to trace the development of its disciplinary functions.

32 Crowther, M Anne, ‘Forensic Medicine and Medical Ethics in Nineteenth-Century Britain’, in *ibid.*, (pp. 173 - 190).
This chapter is one of two papers on the evolution of the conduct guidance issued by the GMC from the 1880s onwards.\textsuperscript{35} Again, I shall set out an account of this development later, but it is worth noting that Smith does not attempt to relate the guidance of the GMC with any other medical ethical literature, or wider medico-political or social themes. Since his approach is an analysis of jurisprudence and the extent to which the results of this adjudication were communicated back to the profession, his chapter neatly dovetails in a semantic sense with Crowther’s. Whilst Baker’s volume presents an excellent critique of the “revisionist” account of medical ethics, I hope to show in the following chapters, and shall argue in my conclusions that Baker’s assertion that British medical ethics became jurisprudential is, at best, misleading.

Roger Cooter, surveying much of the material discussed above, concluded that the subject, despite the burgeoning and, for him, questionable tide of contemporary bioethical activity, was eminently “resistable” for social historians, and that this literature had not pushed the history of the subject far forward.\textsuperscript{36} He described medical ethics as construing itself as the application of transhistorical, disembodied ethical principles, to an extent that repelled social historians. However, Cooter urged scholars to overcome their distaste and turn their attention to the subject.

\textbf{The work leading up to the current research}

Whilst working in 1992 - 3 on the history of health education, dietary and lifestyle advice in interwar Britain, particularly the campaigning work of Sir William Arbuthnot Lane, I discovered that Lane and a number of his sympathisers had been in dispute with the CEC over the publication of newspaper articles in the lay press.\textsuperscript{37} The material I studied in the Wellcome Contemporary Medical Archives Centre (CMAC)\textsuperscript{38} demonstrated that a confidently held set of ideas guided the work of this committee, even though Lane was able to publicly challenge their stance on this particular issue. Veiled references to a “Pratt Case” and “the Coventry Case” attracted my attention. I found that these related to a successful legal challenge to a scheme that the BMA had put in place to ensure that certain medical appointments were boycotted. The rules under which this scheme ran were called “ethical” and yet the scheme itself had been applied with ruthless disregard, and had attracted severe censure from the trial judge. (This case is discussed in Chapter 6.)

\begin{footnotesize}
\textsuperscript{36} Cooter, Roger, ‘The Resistible Rise of Medical Ethics’, \textit{Social History of Medicine, 8}: 1995, 257 - 270.
\textsuperscript{38} CMAC, Wellcome Institute for the History of Medicine, 183 Euston Road, LONDON NW1 2BN
\end{footnotesize}
undertook an initial examination of the archives held by the BMA (BMAA) in my spare time in 1994 - 5, and this work demonstrated that the CEC had been very busy indeed. It adjudicated on matters such as those mentioned, as well as advertising and canvassing, consultation between practitioners, the rights and duties of locums and assistants and had tried to settle numerous disputes between individual doctors. The only subject familiar to me, a doctor trained in the 1980s, as being "ethical" was that of confidentiality. It was very clear that the contrast between the work of this committee and the ethics agenda of the present day required exploration, and that the material in these archives cast a fascinating light on the world of medical practice of the period.

J Stuart Horner's thesis

I had anticipated that much of my research would be taken up with an analysis of the caseload of the committee. However, I discovered that the Chairman of the CEC during the late 1980s and early 1990s, J Stuart Horner, had written an MD thesis describing its work. He had become fascinated by its history, and had examined the BMA archival materials, which at that time were uncatalogued and uncared for. Horner's work was concerned to explore the role of social and particularly religious thinking in medical ethical deliberations, and secondly to analyse changes that occurred in the committee's makeup (with the introduction of lay members) and workload (particularly the instigation of working parties on torture and euthanasia) during the period 1980 - 1992.

My reading of the Committee minutes and Horner's analysis of the caseload convinced me that there was limited value in repeating this exercise. Horner examined the minutes at 5 year intervals and divided cases into "doctor/healer", "doctor/doctor", "advertising", "relationships with other professionals", "doctor/employer", "doctor/state", "moral issues" and "others". These figures showed a huge increase in "moral issues" from 1937 - 1993, a sharp drop in doctor/employer issues after 1952, a long steady decrease in "doctor/doctor" issues after 1907. (I shall not discuss here the problems entailed in separating "moral" problems from the caseload of an ethical committee.) I have retabulated his raw figures below; they also demonstrate how many fewer cases the Committee dealt with after the Second World War.

39 Tavistock House, Tavistock Square, LONDON, WC1H 9JP.
41 J Stuart Horner, personal communication.
Table 1: Horner’s analysis of caseload for the CEC 1902 - 1993

<table>
<thead>
<tr>
<th>Year</th>
<th>doctor/healer</th>
<th>doctor/doctor</th>
<th>advert</th>
<th>other profs</th>
<th>employer</th>
<th>state</th>
<th>moral</th>
<th>other</th>
<th>total cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902/3</td>
<td>1</td>
<td>6</td>
<td>17</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>28</td>
</tr>
<tr>
<td>1907/8</td>
<td>1</td>
<td>199</td>
<td>63</td>
<td>3</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>280</td>
</tr>
<tr>
<td>1912/3</td>
<td>7</td>
<td>50</td>
<td>27</td>
<td>1</td>
<td>90</td>
<td>4</td>
<td>0</td>
<td>8</td>
<td>187</td>
</tr>
<tr>
<td>1917/8</td>
<td>6</td>
<td>35</td>
<td>16</td>
<td>0</td>
<td>58</td>
<td>5</td>
<td>2</td>
<td>11</td>
<td>133</td>
</tr>
<tr>
<td>1922/3</td>
<td>6</td>
<td>34</td>
<td>25</td>
<td>0</td>
<td>129</td>
<td>3</td>
<td>0</td>
<td>5</td>
<td>202</td>
</tr>
<tr>
<td>1927/8</td>
<td>5</td>
<td>26</td>
<td>30</td>
<td>1</td>
<td>34</td>
<td>5</td>
<td>0</td>
<td>5</td>
<td>106</td>
</tr>
<tr>
<td>1932/3</td>
<td>1</td>
<td>34</td>
<td>18</td>
<td>13</td>
<td>49</td>
<td>3</td>
<td>0</td>
<td>6</td>
<td>124</td>
</tr>
<tr>
<td>1937/8</td>
<td>1</td>
<td>35</td>
<td>14</td>
<td>7</td>
<td>64</td>
<td>1</td>
<td>15</td>
<td>1</td>
<td>138</td>
</tr>
<tr>
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<td>20</td>
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<td>1</td>
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<td>50</td>
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<tr>
<td>up to 1943</td>
<td>29</td>
<td>439</td>
<td>216</td>
<td>26</td>
<td>454</td>
<td>24</td>
<td>18</td>
<td>42</td>
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<td>1952/3</td>
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<td>12</td>
<td>16</td>
<td>9</td>
<td>15</td>
<td>4</td>
<td>94</td>
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<tr>
<td>1957/8</td>
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<td>24</td>
<td>10</td>
<td>12</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>3</td>
<td>67</td>
</tr>
<tr>
<td>1962/3</td>
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<td>25</td>
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<td>6</td>
<td>7</td>
<td>1</td>
<td>16</td>
<td>7</td>
<td>70</td>
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<tr>
<td>1967/8</td>
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<td>18</td>
<td>12</td>
<td>16</td>
<td>6</td>
<td>103</td>
</tr>
<tr>
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<td>49</td>
</tr>
<tr>
<td>1977/8</td>
<td>1</td>
<td>7</td>
<td>10</td>
<td>6</td>
<td>2</td>
<td>7</td>
<td>27</td>
<td>7</td>
<td>67</td>
</tr>
<tr>
<td>1982/3</td>
<td>0</td>
<td>10</td>
<td>1</td>
<td>9</td>
<td>16</td>
<td>0</td>
<td>49</td>
<td>8</td>
<td>93</td>
</tr>
<tr>
<td>1987/8</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>0</td>
<td>39</td>
<td>9</td>
<td>62</td>
</tr>
<tr>
<td>1992/3</td>
<td>0</td>
<td>4</td>
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<td>0</td>
<td>0</td>
<td>32</td>
<td>10</td>
<td>49</td>
</tr>
<tr>
<td>up to 1993</td>
<td>31</td>
<td>580</td>
<td>300</td>
<td>91</td>
<td>574</td>
<td>64</td>
<td>248</td>
<td>108</td>
<td>1996</td>
</tr>
</tbody>
</table>

My own initial impression was similar, but it was also apparent to me that it was difficult to put many cases into any one category. Thus whilst the case of Eric Yule was, on the face of it, simply a complaint about advertising consulting times in a local paper, it was clear from the materials in the CMAC file relating to his case that it was partly a dispute between two surgeons. In other words although it was a case of advertising, it was also, less obviously a doctor/doctor dispute. The case of Dennis Vinrace was more complex. In 1903 the “attention of Association” was called “to a prospectus from which it appeared that Mr Dennis Vinrace was acting as Director of a Company formed for the preparation and sale of a proprietary medicine”. In fact he was not acting in that capacity, but the CEC found that “when the matter was brought to his knowledge” by his colleagues he had failed to “take sufficient or proper steps to vindicate his own honour or that of the

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43 CEC, 15.3.1932
44 See, CMAC SA BMA D 161
profession”. And so the “offence” if any was either advertising or associating with trade in patent medicines (a category not mentioned in Horner’s list). Mr Vinrace was eventually expelled from the Association, but the reason for this was “his persistent refusal to apologise” either to his local Branch ethical committee, or to the CEC, for what had occurred. As it happens, Horner’s case selection (every 5th year after 1902) would have missed this case out. However it illustrates that whilst there were specific technical offences these were embedded in a whole culture of professional discipline and honour, and it was against the latter that Vinrace had offended most.

**Research materials and methods**

These considerations, along with the fact that I had access to materials that had been taken from the uncatalogued BMA collection and transferred to the CMAC, lead to me adopt a different approach. These archival materials were not the bound minute books, document books and other more formal documents still held by the BMAA today, but files built up by the BMA secretariat on various topics. These consisted of bundles of excerpted minutes and agendas along with correspondence in original form, handwritten notes, and other ephemera. Some of these related to specific cases, others to specific issues or long-running problems. What is not certain is why the files were made up in the first place, but it does not seem unreasonable to suppose that these issues and cases were considered either particularly important, or difficult. It seemed reasonable to follow this structure to a certain extent as a proxy marker for what the BMA found difficult or important in its ethical work during this period. However an important caveat needs to be made. Whilst minutes and other formal “documents” for meetings found their way into these bundles from the whole of the period 1902 - 1939, it is clear that the other items, correspondence and ephemera were only being collected in this way from around 1920 onwards. The volume and detail of these files became progressively greater towards the end of the period. Some material has been lost, since some items alluded to are not present. It is possible that important material was left out of each file; but in general those who made them up tended to be over-inclusive; collecting every minute and draft relating to the topic so that the files are dense and difficult reading. That said the issues “made up” into files were almost always ones that were important in the literature too.

Thus I had two sets of intimately related archival material, the first a sequential set of minute books (not only for the CEC, but every other committee of the BMA) and the second a thematic set of files. The material, particularly that in the CMAC, is extremely rich, and would bear further study, either primarily for its “ethical” content or for the information it contains on the world of medical

[^45]: CEC 14.7.1905
practice. I decided to proceed along two lines. Firstly I read through the CEC minute books in chronological order simply taking note of interesting cases, issues, procedural questions, and most importantly the dates and members attending each meeting. I next turned to the CMAC files examining any that fell within the time-frame chosen for the study, which I had set at 1939 for a number of reasons.

I next read the main primary published works on medical ethics or doctors’ conduct from the period. It was only after completing this phase of the project that I turned to the secondary literature, since I prefer to approach primary source materials, particularly those that have never been examined, with as few preconceptions as possible.

**General Ethics - the “missing factor”**

One result of this approach was that whilst it would have been anticipated that a reading of the contemporary literature on ethics and religious thought would be an essential part of this project, I found minimal discussion of general ethics or religion in the primary materials. The principles that were adduced were commonplace, simple and, most importantly, not worked into detailed consideration of medical ethical problems. (These will be discussed further in Chapter 5.) Thus a detailed discussion of early twentieth century ethical thought in relation to this project would have been an ahistorical imposition.

What is more, the works I have consulted on the history of ethics indicate that this “missing factor” was not “missing” by mere co-incidence. Ward, Warnaock, and Toulmin writing in the 1920s, 1960s and 1980s respectively and all noted that ethics had been becoming increasingly abstract in the early twentieth century. The wrangles between those who saw moral principles and goodness as absolute given values, and naturalists and relativists of varying hues, and later semantic arguments were not grounded in medical practice or indeed any other practical problem. Warnock’s *Ethics since 1900* concluded with the hope (rather striking given her subsequent work) that the subject would become more about “actual choices and actual decisions” than abstraction. Indeed Toulmin asserted that the application of ethical philosophy to biotechnological and medical problems "saved" ethics from low status and obscurity. Certainly Ward, writing for the intelligent layman,

was at pains to point out the usefulness of ethical ideas to the adjudication of everyday problems, despite all appearances to the contrary.

**Chronology**

Originally the intention had been to study the period up to 1948. However the richness of the material, the "quietus" caused by the War, and the fact that by 1939 the committee seemed to have slipped into a routine repertoire of cases, and was not considering many new issues, all indicated an end point of 1939. Whilst I had identified published works relating to the subject of medical ethics and related areas from the late nineteenth century through to the 1970s the impression I had gained of a pre-war status quo in medical ethics was confirmed by the paucity of the literature prior to the period after the War. I felt that continuing the study further in time would add nothing to the essential points made, but would add considerably to the exemplification and detail. At the same time, it also became clear that, particularly in "setting the scene" a great deal of work was required to cover the developments of the 1890s, which was far more important to make sense of the material studied.

The next problem was to decide how to structure the study. Caseload analysis had already been performed by Homer, and a purely chronological approach seemed likely to be confusing, since different kinds of problems were repeatedly considered. Examination of the files dealing with particular issues revealed that at any one time only one or two ethical issues were the subject of detailed scrutiny or heated debate, and it was clear that there was chronology to the themes, at least in this respect. Each theme has one or two chapters, and I have arranged the chapters to reflect this informal chronology as far as possible. However it has become clear that there is no optimal linear arrangement in which to place these topics, and a great deal of cross-referencing between chapters has been unavoidable. The major drawback of this approach is that I have not examined inter-practitioner disputes at length, although the principles involved have almost all been discussed.

The second point on which this current study differs from Homer's is that I have undertaken a more thorough reading of the literature outside the BMA, and attempted to say more about the different organisations involved in medical discipline and conduct issues. I have also attempted to set each theme within a longer historical context by referring to the nineteenth century codes of medical ethics for each one.
Thesis Outline

In the next chapter I shall set out the history of the BMA and its involvement in medical ethics, and the relationship between its attempts to codify and consider ethics and the profession's wider medico-political concerns. I shall then describe the organisation, prosopography and workload of the CEC, before moving on to describe the work done by a selection of other medical organisations - the GMC, RCP of London, and the MDU - in medical conduct and ethics. The final chapter in the first section is a review of the literature between 1890 and 1939.

In the second section I resume part of the "story" told in Chapter 2 concerning the ethics of holding disputed appointments, and the general ethical rules set out by the BMA in the early 1900s. In the following chapter I shall discuss the focus of many of these rules, a 'traditional' part of medical ethics and etiquette, the consultation between two or more doctors on a case. Consultation and collaboration with the unregistered and unqualified are considered in the next chapter which will also examine the way in which different healthcare professions emerged and used ethical codes to negotiate their relationships with each other. The issue of advertising was important and broad enough in its ramifications to require two chapters. In the first I consider the ethics of advertising or drawing attention to the individual practitioner, and in the second I deal with the questions of doctors' involvement in marketplace advertising for medical enterprises of various types. The next chapter was originally intended to set the scene for the chapter on confidentiality by describing the legal and cultural history of divorce, venereal disease and abortion. The position of abortion in relation to medical ethics was interesting enough for this section to be expanded, partly to illustrate the way in which an apparently obvious "ethical" question could be largely left out of "medical ethics". I then turn to the question of professional secrecy (confidentiality), a long chapter brings out a number of points not apparent in the other themes examined. Lastly I have dealt with lay complaints, an important subject, but with little archival material to draw on.

In the last section I shall summarise the content of the BMA's 1949 code of ethics - itself a summary of the work of the CEC since its foundation, and sketch out subsequent changes in medical ethics. In the concluding chapter I shall draw the material together, and propose my central findings.

There are two appendices. The first contains the alphabetically ordered biographical sketches of actors central to the thesis (others are given shorter biographies in footnotes, or in the main body of the text). I shall only refer to these biographies when the actor concerned is first mentioned, but
there would be some value for the reader in reading these through together before the main body of the text. The same could be said for the second appendix, my 1994 paper on Arbuthnot Lane, health education and indirect advertising, which was the starting point of the research for the current work. It was not possible to entirely separate that work from the current account, but I have clearly indicated where sections are summaries of the previous work.

Technical points

Footnotes

For the sake of clarity and brevity, citations of committee minutes are given simply as “Committee, date”, except where the information relating to the committee is only available in the BMAA. Where a document, agenda or memorandum for that meeting is being cited, these are indicated simply using these terms, since document numbering and pagination was inconsistent. Again, the source is indicated where I believe the information to be available in one or other archive only. Published works are cited with full details only on the first citation in the thesis as a whole, and thereafter simply as author surname, abbreviated title, and date.

Gender

I have retained the gender bias present in the sources.

Anonymity

Since the youngest registered doctors in 1939 would now be over 83 years old and most “cases” involve “offences” that would not any longer be regarded as problematic I have not anonymised my text. Where more serious offences are involved I have only given names where these were proven in a Court, or already in the public record.
**Glossary of special terms**

**Attending practitioner**  
The doctor who usually undertook the care of the patient, the family doctor, or in later terminology, their Panel doctor or GP.

**canvassing**  
The use of leaflets or doorstep representatives to induce patients to use a doctor's services, or those of an organisation employing him.

**consultant**  
Either a doctor called in to give advice, provide special skills or to give a second opinion; or a doctor with a major hospital appointment who almost always saw patients who already had an “attending practitioner”

**covering**  
Enabling an unregistered practitioner to practice “as if” they were qualified, a specific form of association with the unregistered.

**erasure**  
Removal from the Medical Register, being “struck off”

**supersession**  
Taking a case over from another doctor, either with or without their knowledge

**Abbreviations**

A large number of abbreviations have been used, and almost all are detailed at first use

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMA</td>
<td>British Medical Association</td>
</tr>
<tr>
<td>CEC</td>
<td>Central Ethical Committee (initially Ethical Committee), of the BMA</td>
</tr>
<tr>
<td>GMC</td>
<td>General Medical Council</td>
</tr>
<tr>
<td></td>
<td>(formally the General Council for Medical Education and Registration)</td>
</tr>
<tr>
<td>GPC</td>
<td>General Practice Committee, of the BMA</td>
</tr>
<tr>
<td>GPEC</td>
<td>General Practice and Ethical Committee, of the BMA</td>
</tr>
<tr>
<td>MDU</td>
<td>Medical Defence Union</td>
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<tr>
<td>MPC</td>
<td>Medico-political Committee, of the BMA</td>
</tr>
<tr>
<td>MPS</td>
<td>The London and Counties Medical Protection Society</td>
</tr>
<tr>
<td>RCP</td>
<td>Royal College of Physicians, of London</td>
</tr>
<tr>
<td>LRCP</td>
<td>Licentiate of the RCP of London</td>
</tr>
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<td>MRCP</td>
<td>Member of the RCP of London</td>
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<td>FRCP</td>
<td>Fellow of the RCP of London</td>
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<td>Royal College of Surgeons of England</td>
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<td>RSM</td>
<td>Royal Society of Medicine</td>
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<tr>
<td>s/c</td>
<td>sub-committee</td>
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<tr>
<td>LSA</td>
<td>Licentiate of the Society of Apothecaries</td>
</tr>
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<td>Bachelor of Medicine, Bachelor of Surgery; English Universities</td>
</tr>
<tr>
<td>MB CM</td>
<td>Bachelor of Medicine, Master of Surgery; Scottish Universities</td>
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<td>JC</td>
<td>Journal Committee</td>
</tr>
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<td>JP</td>
<td>Justice of the Peace</td>
</tr>
<tr>
<td>LGB</td>
<td>Local Government Board</td>
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<td>Medical Officer of Health</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<td>VD</td>
<td>Venereal Diseases</td>
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Chapter 2

The BMA and medical ethics, 1832 - 1902

Introduction

In this chapter I shall describe the development of the BMA from its relatively humble beginnings up until the point at which it emerged as a newly constituted organisation in 1902. I shall also demonstrate that despite interest in the subject of “ethics” from the earliest days of the Association, this interest did not translate into clear advisory, regulatory or codificatory activity prior to the new constitution and the setting up of the CEC. In this account I will draw out the tension between the founding impulse of the Association, which arose from a strong localist, voluntarist, and sociable culture, (still evident in local medical societies during the period studied,) and desire of many doctors for a strong, well organised national body to promote their medico-political agenda.

It was no accident that the new constitution solved the problems of medical democracy and the need for useful work in disciplinary and conduct issues at the same time. Medical politics and ethics can only be separated in the history of the BMA in the nineteenth century by an imposition of contemporary distinctions and categories. They were seen as linked, and particularly in the area which most pre-occupied ordinary medical practitioners at the close of the nineteenth century: contract practice. Despite this, and the imperfections of the Association as a medico-political organisation, the nineteenth century Association was far more successful in politics than in ethics. Indeed the years 1832 - 1895 were characterised by repeated failures to deal with medical ethics formally. In the 1895 an ‘ethical’ function was assigned to a General Practice committee, but it found itself unable to do much useful work.

The early BMA and Medical Ethics

Founding ideals

The BMA was founded as the Provincial Medical and Surgical Association (PMSA) in 1832 at a meeting of 40 doctors convened in Worcester Infirmary by one of its physicians, Charles Hastings.

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1 I have based my account of the general development of the BMA primarily on the account given in Bartrip, Peter, *Themselves writ large, the British Medical Association, 1832 - 1966*, London, BMJ, 1996. Earlier histories of the Association, are only cited where they give information not present in Bartrip, or as primary sources.

2 Charles Hastings, (1794 - 1866) “the leading man of his day in the Midlands” was the 9th of 15 children of a Ludlow Rector, and was brought up in Martley near Worcester. He was educated at local village school (of “good reputation”)

29
This was, as all accounts of the BMA point out, the 'Age of Reform'. 1832 saw the passing of the Reform Act, which rationalised and extended the franchise to a wider section of the respectable propertied classes, after a decisive General Election fought on the issue in 1831. Medical men, in keeping with this mood, were increasingly dissatisfied with the way in which their professional life was organised under the Royal Colleges, and wanted organisations that furthered their medico-political, social and scientific needs more actively. The latter two areas received greatest attention in the founding aims of the Association. These “objects” were firstly, to collect and disseminate useful medical information, secondly to “increase [the] knowledge of the medical topography of England”. The third aim was essentially a restating of these two aims, to be supported by a fourth, the “advancement of medico-legal science, through succinct reports”. Lastly the Association’s aim was the

Maintenance of the honour and respectability of the profession, generally, in the provinces, by promoting friendly intercourse and free communication of members; and by establishing among them the harmony and good feeling which ought ever to characterise a liberal profession.4

As I shall show later, this formulation entailed an ethics of its own in the minds of Victorian medical men, but Hastings’ founding speech also explicitly discussed “Medical Ethics”, saying,

It is strange that with the exception of a few meagre essays, no attempt has been made to establish a code for the guidance of those who need such direction. In a well organized profession, there could be no difficulty in adapting to its exigencies the doctrines of general Ethics, the principles of which exist in every well-governed mind, and are identical in all circumstances, however variously they may be applied. Except the brief tracts of Gregory and Percival, we have no guidance furnished to us in this respect; and a well-digested code, adapted to the complex and much altered condition of the profession is yet a desideratum.5

His statement appears with hindsight not only hopelessly optimistic, but failed to anticipate the main stumbling block for the Association’s involvement in medical ethics; that of detail rather than principle. It was not until 1949 that the Association felt able to publish such a “well-digested code”.  

and apprenticed to two surgeon apothecaries in Stourport for a year and a half when he was 16. After this he went London to “walk the wards”. Between 1812 and 1815 he was House Surgeon to Worcester Infirmary and then went up to Edinburgh, where he graduated MD in 1818. In 1824 he inherited his father-in-law’s “large and lucrative” practice, and this income, coming so early in his career allowed him to pursue his interests. Described as usually “emollient and amenable”, he could be both assertive and persistent. See: Bartrip, Themselves writ large, p. 12.


4 Trans. PMSA, 1833, i: 10.

5 ibid., 24 - 5.
The early history of the BMA

From the start the Association absorbed other local medical societies as branches, the first being the Eastern PMSA which became its Eastern Branch in 1837. The early and abiding device of holding the Annual Meeting in different provincial towns each year furthered contacts with other local groups. However the Association always had a “centre” first at Worcester, then briefly in Birmingham, before finally making the perhaps inevitable move to London. Particularly in these first two phases, a strong clique of Worcester and Midlands doctors tended to control the Association through its Council, with Hastings playing the leading role until his death in 1866.

The move to London was not fully accomplished until the late 1870s, although it can be seen as starting during what Bartrip refers to as the BMA’s “constitutional crisis” in the 1850s. In 1853 the Association acquired, (or was joined by) a Metropolitan Counties Branch. This contained members living in and around London, and was rapidly to become a powerful and large part of the organisation. In the same year the Provincial Medical and Surgical Journal moved to London. It was re-named the Association Medical Journal, and became the British Medical Journal (BMJ) in 1857. In 1855 the Association had acquired a new constitution to replace the old Worcester-based Council of men originally invited by Hastings, and whom “death alone deselected”. This was intended to be broadly analogous to the British system of parliamentary democracy: the membership constituted the electorate, the general Council, the House of Commons; and the Executive Council the cabinet, within which the President of the Council corresponded to the Prime Minister. The constitution still allowed Hastings to retain the Presidency for life, as indeed he did. A referendum of members in the same year decided to change the name to the British Medical Association, an organisation of the same name, set up by George Webster, having collapsed.

Bartrip explains the survival of the Association in the 1850s as stemming from two main factors. The first was “sentimental attachment” and the second a strongly felt need for a national representative organisation. Whilst the newly constituted BMA had defects as a representative structure it was perhaps better suited than any other organisation. The main focus for this perceived need was the long campaign for Medical Reform, which after a long series of failed Bills introduced over nearly two decades, finally came to fruition in the Medical Act of 1858. The Act, which established the Medical Register and the GMC, was not all that many activists had hoped for.

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7 ibid., p. 37.
legislative ban on 'unqualified practice', democratic control of the GMC by the profession, and the single portal of entry were all missing from the statute. The Act of 1886, for which the BMA also campaigned, introduced some changes, most importantly the Conjoint Examination and Direct Representatives on the GMC, but in essence these aims were to remain elusive during the whole of the period studied. Despite these disappointments, the BMA, which had been involved in presenting successive Bills to Parliament as a body representing medical men of all sorts, could look with some satisfaction on the achievement of the 1858 Act, and gained some prestige by it.

By this time most of the BMA’s business was being transacted in Birmingham rather than Worcester, but always in public rooms and private houses. Even though by 1875 the Association’s membership amounted to a quarter of all registered medical practitioners, the only property devoted to any of its activities was a pair of rooms, housing two BMJ clerks, in a house at Great Queen Street, London. It was the Journal that was to play a vital role in pulling the still small Association into a stronger and stronger position, largely under the editorship of Ernest Hart between 1866 and 1898. Hart succeeded in making the automatic subscription to the Journal an incentive to membership by raising its profile and quality through the last third of the 19th Century. This in turn rested on the massive expansion of advertising space, and the increased profitability following the Association’s move to 161a The Strand in 1878, a building large enough to allow in-house printing. This “trade-like” development, and others such as the payment of travelling expenses for Council members (many of whom failed to appear at all), were resisted by members who treasured the liberal gentlemanly voluntarism of the Association. Nevertheless the Association prospered, between 1867 and 1887 the its assets increased from a balance of £1208 to a total of £20,000 in investments alone. Hart also played a key role in the Parliamentary Bills Committee which, during the latter quarter of the nineteenth century drafted legislation, lobbied government and kept an eye on any legislation that might affect the medical profession.

These changes did nothing to address a long-standing tension within the BMA between the local “rank and file” and the central “elite”. Despite its origins as a locally based organisation and its Branches throughout the UK, the BMA retained a centre that was stronger than its periphery. This, and a similar tension between general practitioners and ‘consultants’ was apparent in periodic complaints about the unrepresentative nature of the Association throughout the century. Of the changes made later in the century the most important were the establishment of the permanent Parliamentary Bills Committee in 1867, (each issue having hitherto been tackled by ad-hoc

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committees), and the reforms of 1874. The objects of the Association were updated to be simply "the promotion of the medical and allied sciences and the maintenance of the honour and interests of the medical profession."

The reforms also abolished the Committee of Council, giving full executive power to quarterly meetings of the Council, but this did not succeed in making the Association more democratic. The Council numbered 92 by the 1890s, and it is surprising they managed to do anything at all. Furthermore Branches of the Association covered large geographical areas, and despite the growth in the railways considerable investment of time would be required for members to attend even "local" meetings, let alone central ones.

The early BMA and medical ethics

Despite Hastings' hopes, and the interest of many members, the production of a code of medical ethics was not actively pursued by the Association during the first two decades of its existence. This was in marked contrast to the AMA, which produced a Code, based on Percival's, as almost its first task when it was founded in 1846. Prompted by this alacrity, John Conolly proposed in 1849 that an Ethical Committee be formed to accomplish a similar task. By 1851, some rules had been set out, but the Committee found itself unable to meet and discuss others over which there was disagreement. The election of new members in 1853 failed to remedy this problem, and no report was ever made.

A new committee of 32 was set up in 1858, chaired by Hastings, and including the eminent Robert Christison. Another member, Jukes de Styrap, was added in 1859, but the committee never

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10 BMA, Yearbook 1905, BMAA B55/15/2, pp. 36, 67 - 71
11 Leake, Chauncey, Percival's Medical Ethics, Baltimore, William & Wilkins Co., 1927, p. 49.
12 Conolly, (1794 - 1866) whose father "remained without definite position or calling", despite wealthy Irish forbears, started life as a soldier. Having run out of money, and needing to support his family, he turned to medicine and studied at Edinburgh between 1817 and 1821. He never settled long in one place, practising first in Lewes and Chichester, then in Stratford on Avon gaining some success as a general practitioner. In 1827 he was appointed Professor of Practice of Medicine at UCL, but did not succeed in London. He moved to Warwick in 1830, and was involved in the founding of the PMSA. In 1839 he went to the Middlesex Asylum at Hanwell and introduced the ideas and practices of the Tukes of York and Drs Charlesworth and Gardiner of Lincoln, under the rubric of "non-restraint". Despite the ultimate failure of this policy, and the fact that his real strengths were writing and administration, this made Conolly's name.
14 Christison (1797 - 1882) whose father was a Professor of Humanity at Edinburgh was educated and spent his professional life at the University. He graduated in 1819, and worked at the Royal Infirmary, St Bartholomew's and later in Paris. He was put up for the Edinburgh Chair in Medical Jurisprudence by his twin brother during this absence, and was granted the post in 1822. In 1827 he became Physician to the Royal Infirmary. As medical advisor to the Crown he was involved in almost all important cases in Scotland and many in England, and was renowned as a clear, emphatic and candid witness. With his interest in chemistry and toxicology he made his subject more scientific. Between 1832 and
produced a report, let alone a code. De Styrap however went on to produce his *Code of medical ethics* in 1878, a book which reached a fourth edition in 1895, and was the only such code of rules, aside from regulations of the Colleges, during the last quarter of the century. This work will be discussed later in this thesis.

Two related sets of sources throw some light on the ethical concerns that drove this desire to formulate a Code. Firstly de Styrap’s book itself was largely concerned with the need to set a high moral tone within the profession in order to overcome problems of professional jealousy, and promote *esprit du corps*. De Styrap perceived this as an enormous problem, and the rules he set out on how doctors, ‘members of the faculty’, ought to behave towards each other served this larger purpose. The second was the long-running debate in the Association over the status of medical homeopaths. The rising popularity of homeopathy was seen as a threat to the organising profession in the 1850s, and in 1851, speaking at the Annual Meeting, Hastings addressed the problem of the “delusion”, linking it to ethics and the activities of the BMA.

It is highly desirable that we should give a calm and judicious attention to medical ethics; for it is much to be regretted that many regularly educated members of our profession have connected themselves in doctrine and practice with some of the popular delusions of the day. It will be by the judicious consideration of such important matters that the advantages resulting from this Association will become more and more apparent. The inflexible adherence to correct principles and upright conduct will thus continue to be the rallying point of the members of the Association and they will evince their determination to maintain among themselves a sound philosophy and unblemished honour.

Thus for Hastings the boundaries of the profession were not only behavioural, and moral, but also philosophical. Conolly denounced this sectarian view at the same meeting, saying that the “perfect scene of uproar with denunciations of homœopathic practitioners” was “undignified” and “degraded” the profession. “If homœopathy were a delusion, it would die away; if there were any truth in it, they should give the truth a chance of growing up. They had no right to say that the principles they held were the true ones and all others false.”

1877 he became Professor of Materia Medica and Therapeutics and of Clinical Medicine to 1855. He was made a Baronet in 1871.  
Source: *DNB.*

17 Horner has described homeopathy as the only ethical issue discussed by the BMA in the 1880s.  
18 *PMSJ*, 20th August, 1851, pp. 456 - 7  
19 Bartrip, *Themselves writ large*, 1996, p. 77
Although in 1852 the Association decided not to admit homeopaths and to expel members who met with them, there were very few expulsions indeed, and the Association’s policy toward homeopaths tended towards Conolly’s view. This is not to say that in many areas homeopaths were not shunned; those regular doctors who flirted with it “courted victimisation, ostracism and professional ruin”.\(^{20}\) We shall return to this issue later, but a number of points are worth noting here. The notion of the professional group is key, and the behaviour of the members of the group towards those inside and outside was an essential defining issue, amounting to a moral imperative. This centred on “association” in two senses, belonging to the organisation, and meeting in consultation over a case. Another point is the tension between the notions of gentility and liberality within the profession and the need to assert the position and rightness of that profession’s status in society. A very similar set of ideas and methods were deployed against those who co-operated with certain forms of contract practice later in the century.

**Contract practice**

**Background information**

Contract practice was the contemporary term for any medical work provided on a subscription or capitation basis, as opposed to the fee-for-service payments customary in private practice. The issue was to be so contentious that it is hard to find accounts of contract practice that are not partisan either in intention or in derivation. Many accept the doctors’ point of view, either deliberately, or because of the influence of the writings of two men, Alfred Cox\(^{21}\) and James Smith Whittaker,\(^{22}\) who were deeply opposed to it. Smith Whittaker’s Report on Contract Practice\(^{23}\) was the most complete survey of its time, and influenced both governments, and those pushing for reform, like the Webbs.\(^{24}\) The writings and activities of medico-politically active men like Alfred Cox\(^{25}\) were almost all devoted to wresting control of contract practice away from the laity. David Green on the other hand sought to portray contract practice as a healthy social phenomenon.

\(^{20}\) _ibid._, p. 322.

\(^{21}\) See biography, p. 322.

\(^{22}\) See biography, p. 235.


essentially without defect, that was destroyed by doctors’ dogged pursuit of their economic interests.26

It is clear, however that by the turn of the century numerous types of organisation had sprung up that employed doctors to provide contract medical services. They ranged from the various mutual aid societies which had sprung up increasingly through nineteenth century, like the Ancient Order of Foresters, Heart of Oak Society, or the Oddfellows,27 and also included Provident Dispensaries and works schemes, such as colliery medical clubs. Many of these were local organisations, or national organisations with local “lodges” and almost all were controlled by committees of working class men. These organisations had from the late nineteenth century been joined by commercial concerns such as Medical Aid Societies and Life Assurance companies, many of which provided contract medical care as an incentive to buy insurance policies, or as frankly commercial ventures. These were all lay controlled organisations, but the term contract practice was also applied to private doctors’ clubs and Public Medical Services, which were organised by doctors themselves.28

These lay controlled organisations offered a wide variety of benefits to their members, of which medical attendance could be but one, and this variety was further compounded by widely varying rates of capitation, rules, rates for family members and terms of service. The attitudes of doctors, organisers and users of these services also varied in each locality. The numerical extent of contract practice in all its many forms is difficult to estimate, but it is reasonable to suppose that the vast majority of working class families were either partly or wholly catered for on this basis. A good many middle class families used contract practice arrangements too. One estimate is that three quarters of those persons eventually covered by the National Insurance Act of 1911 were already covered for medical attendance by contributory schemes of one sort or another.29

By the close of the nineteenth century contract practice was an important source of income for the majority of family practitioners.30 However, relations between doctors and lay organisers were in many areas deteriorating rapidly, the chronic low grade rumblings of discontent that had continued for decades were growing in volume, and the sporadic “local difficulties” that occurred throughout

26 Green, David, Working class patients and the medical establishment, Aldershot, Gower, 1985.
28 “Investigation into ... Contract Practice...”, Br.med.J. 1905, ii; supplement, 22.7.1905, pp. 16 - 23.
29 Green, Working class patients, 1985, pp. 93 - 96.
the century were becoming more complex and rancorous. Broadly the medical objections fell into three categories.  

Capitation rates: that is that subscription rates were too low to provide a reasonable standard of medicine without pauperising the doctor. A sub-type of this objection was that some organisations expected the doctor to pay for medicines and appliances out of the subscriptions too. A second broad objection related to workload: that subscribers or the organisers were too demanding or clinical workload unreasonably onerous. The last broad objection was often the most contentious, that of the wage limit: that is, that people who were wealthy enough to afford full private fees were subscribing to Contract arrangements. A related issue here was the inclusion of the families of the (male) subscribers for little extra.

Many doctors saw contract practice as a concession to the less well-off, (an attitude Friendly Societies found patronising), or as a useful way to build up a practice. However, as the century progressed there were many who felt it had become nothing more than a systematic method of obtaining medical attendance at a low price. Worse, it represented the exploitation of the professional by the working man. These problems were seen to continue to exist because in many instances where organised resistance was tried, there were local or incoming doctors willing to enter these contracts or to undercut the rates of their professional brethren. This was exacerbated as the century progressed by the problem of medical overcrowding, that is, the relative oversupply of doctors in certain urban areas, to which I shall return in chapter 9. Thus contract practice, as a medical problem, shared some features of homeopathy - medical solidarity, professional unity and individual conduct - and was as we shall see also construed as an issue of “medical ethics”.

**Ostracism in contract practice disputes**

It would be inappropriate to consider 70 years of contract practice disputes in detail here; rather I will focus on the inter-linked areas of medical politics, ethics and organisation in these disputes. In an early example of proposed ostracism of boycott-breakers, the doctors of Oldbury (Staffordshire) in dispute with local Friendly Societies in 1869, pledged themselves “neither to meet them professionally, nor socially; and ... further ... not ... to meet in consultation any physician or surgeon who recognises them”. Such campaigns met with mixed success, but were not characterised by the bitterness typical of later years. Rates were often increased to 5s. per annum “without any undignified pressure but from reasonable and courteous representations”. However the

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31 Citations supporting this summary appear in following pages.


33 Br. med. J., 1869, ii: p. 32.

organisation of contract practice was changing, with increasingly large groups of subscribers organising a full-time salaried medical service for themselves. Perhaps the earliest such Medical Institute, set up in Preston in 1870 was organised in response to “the Preston medical trades union”. Conditions of service for doctors employed by these organisations varied widely, but in 1887 one described his post as “a very pleasant berth”. Even where such good conditions prevailed, the comprehensive family service offered by these organisations cut badly into private medical practice, and private doctors’ clubs.

By the 1890s increasing numbers of disputes occurred, marked by increasing levels of organisation and bad feeling. Ostracism appears to have become a common tool, if only used as a threat, in these disputes. In a dispute in Cork in 1894 it even appeared to be an effective method, if carried through. Here the issue, as in many other places, was the wage limit. The city’s club doctors all resigned their posts, and when new doctors were imported they refused to meet any of them “as professional brethren”. The isolation was sufficient to “break” the clubs, and “patients ... returned on fair terms to their original medical advisors”. The *Lancet* inaugurated a regular column on “the Battle of the Clubs”, a battle which it “expected” all medical men to join. But things did not always go as they had in Cork. In Great Yarmouth, in response to the extension of provision to families, the town’s doctors made a “combination” and demanded higher pay, but the Friendly Societies retaliated by forming an Institute. The men imported to staff were isolated by the Yarmouth doctors (who included James Smith Whittaker). However, the Institute doctors were able to get consultants in London, and the campaign failed.

In other places such as in County Durham, and particularly in Gateshead, another key player, Alfred Cox, was meeting with much greater success. Cox was essentially a liberal working class man, who felt that division amongst doctors perpetuated the poor conditions and rates in contract practice. His first move in Gateshead was to get the town’s doctors to meet socially, and then, having established some degree of accord, managed to persuade the local Society organisers to raise their rates, and allow a free choice of doctor. In this instance no threat of ostracism was mentioned. However, Cox went on to participate in a campaign to improve medical pay in the Durham coalfields under

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35 Green, *Working class patients*, 1985, p. 27. It is clear that Green has quoted the Institute organisers here.
36 *Lancet*, 1887, i: 809.
38 *Br. med. J.* 1896, ii: 408.
the aegis of a new Durham Medical Union. This body passed a resolution in July 1899, which stated;

That when the Qualified Practitioners of any district make a combined effort to raise the standard of their fees, and thereby the status of the profession, it should be deemed infamous conduct in a professional respect for any Registered Practitioner to attempt to frustrate their efforts by opposing them at cheaper rates of payment, and canvassing for patients.  

It is not clear whether the Durham doctors ever had to ostracise any of their colleagues, but several important points are borne out by their resolution. It deliberately used the wording of the GMC’s mandate to erase doctors from the Register, “infamous conduct in a professional respect”. It reflected an increasing tendency to equate membership of the profession with solidarity in medico-political disputes. In other words, issues of honour, status and solidarity were all seen as making the problem one of “conduct” and “ethics”. The GMC maintained the Register that defined the profession and could adjudicate on matters of “conduct”, and remove from the profession doctors whose behaviour was seen as unprofessional. For those working to change the conditions of contract practice it was logical to turn to the GMC to define co-operation with it in its fully lay-controlled and trade-tainted form as unethical, even though it took several years to persuade the Council to pronounce on the issue.

Professional bodies and contract practice

Green has been at pains to describe this as an abuse of a statutory body “in the service of [doctors’] pecuniary interests.” He has assumed that removal from the Register was the equivalent to putting the doctor out of business. This is to overstate the case, since there was no absolute restriction on unqualified practice and, in the 1890s, even fewer statutory inconveniences than was the case later on.  

What he has missed is the power of inclusion and exclusion as tools of moral persuasion. It is clear that the MDU, and to a lesser extent the BMA, contributed to bringing pressure to bear on the GMC to effectively “ban” such activities as canvassing, advertising, “covering unqualified assistants” during the period 1892 - 1905. These were all to some extent, but by no means exclusively associated with lay organised contract practice. Almost all the practices complained of, including employment for low rates of pay, were in fact widely used by doctors quite independent of the Friendly Societies.

40 GMC, Minutes, 1899, XXVI, p. 275.
41 Green, Working class patients, 1985, p. 36.
Indeed there were signs of reluctance to persecute contract practice on the part of both BMA and GMC in the 1890s. The GMC’s initial report on Medical Aid Associations concluded that there was nothing entailed in these organisations specifically to concern it. They found roughly half the doctors were not over worked and roughly half were allowed to engage in private practice, and that most associations did not canvas. This was seen at the time, and later as a failure of the GMC. Fresh agitation, mainly from doctors in Norwich in 1897, resulted in a fresh inquiry, and in 1899 a committee report for the GMC strongly condemned canvassing and touting. The GMC’s slightly tardy condemnation of advertising and canvassing (and to a lesser extent their pronouncements on “covering”) were to prove useful tools in placing some contract practice arrangements beyond the pale. But they were not decisive factors before the introduction of the broader framework the BMA was later to develop. I shall return to the changing rulings of the GMC, and the BMA’s involvement in subsequent chapters.

Medical Ethics and the BMA in the 1890s

Aside from the hitherto rather ill-defined attempts by the BMA to induce some changes in the stance taken by the GMC on issues related to contract practice, there were attempts to raise these and other ethical issues within the organisation itself. Dr Garrett Horder, who was on the Council of the MDU, proposed at the 1894 BMA’s Annual Meeting that there be an Ethical Section at the next annual meeting. Council considered this, along with a letter from Dr T Frederick Pearce saying that there was widespread interest in an ethical section:

it is difficult to define what is meant by an “ethical” section, but all subjects affecting the relations of the members of the profession with each other, and with the public, with medical institutions, and with clubs, questions of fees, irregular practice and a host of other subjects which immediately interest the great body of general practitioners, would be included in its discussions.

43 GMC, Minutes, 1893, XXIV: Appendix XII, “Report of the Committee on Medical Aid Associations”.
46 GMC, Minutes, 1899, XXVI: p. 206.
47 Collins English Dictionary, 1986. “Pale ... an enclosing barrier, ... a sphere of activity within which certain restrictions are applied. ... Beyond the pale: outside the limits of social convention”.
48 Further research is required to discover the links between the BMA, GMC and MDU in the 1880s and 90s.
49 Council, 24.10.1894, in BMAA B/54/2/7.
This section was held in 1895 and its resolutions were referred to the General Practice committee, which had been appointed by Council to "enquire into the grievances, wants and requirements of General Practitioners" and how to "ameliorate" them. As I shall show this committee had already set itself a range of subjects that dovetailed neatly with the resolutions of the Section, indeed the grievances of general practitioners were seen as the primary locus of medical ethics. The section wanted "irregular practice" controlled, and felt that there was "urgent need of some practical steps being taken to deal effectively with the present deplorable lack of esprit de corps and want of cooperation in the profession generally and of which so much undue advantage is taken by the public" particularly in the realm of medical education. The section passed resolutions on hospitals, club practice, advertising, and the ostracisation of any doctor "who wilfully violates generally received rules of medical ethics".

The section met again in 1896 and was evidently very popular; the transcript of this second meeting ran to 20 pages in the *BMJ*. The section had heard papers on "the better governance of a provincial infirmary", and discussed "the abuse of out-patient departments" at great length. Other items included a paper on provident dispensaries, a discussion of "overcrowding in the profession", papers on doctors relationships with parish councils, and with midwives, and on the "ethics of advertising", as well as papers on the "the club question" and medical aid associations. The section resolved that outpatient departments were "morally debasing to the public", failing the "necessitous poor", causing "great injury to the material welfare" of doctors and providing poor medical education. It also resolved that the Association should seek to reform the GMC, and restrictions on pharmacists' prescribing. One resolution roundly condemned working for any organisation that canvassed or advertised, and the use of unqualified assistants to undercut medical fees as "unprofessional", whilst another called for the disqualification of such men from the Association. Lastly they drew the attention of Council to "the chief part of the resolutions passed last year ... have not been dealt with". Council promptly voted to discontinue the Section. The General Practice Committee was not disbanded however, but as we shall see, it did little to upset the "old guard" on the Council.

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50 GPC, 15.1.1895 in *ibid.*
52 *Br. med. J.*, 1896, II: 369 - 89. Only two of those contributing to the section, G H Broadbent and Philip Lee, went on to be members of the CEC.
53 *ibid.*, p. 389, and all subsequent resolutions
54 Council, 20.10.1897, in BMAA B/54/2/8.
The General Practice and Ethics Committee (GPEC)

Whilst this committee was to some extent the forerunner of the CEC, both in terms of general remit and membership, the contrasts between the two committees were marked. It is hard to escape the conclusion that the GPEC was an ineffective sop to the concerns of rank-and-file members, and its ethical function given to it by default. What is more certain, is that the Committee, within the context of the old BMA constitution had little power or clarity of function, and its statements had no clear status. Its annual reports to Council became steadily shorter, consisting in 1900 of a single letter from Coventry. Perhaps the most striking contrast is the way in which the activity levels of the committees changed. After an initial two or three years of enthusiasm, the GPEC quickly ran out of things to do, and had fewer problems referred to it. The CEC’s work quickly gathered in volume and complexity, reaching a kind of organisational “steady state” in which the Committee had a clearly defined and valued workload, by the late 1910s. It is however worth examining the Committee’s work in a little detail here.

The first matter with which the GPEC dealt was an enquiry on ostracism and contract practice. Their correspondent asked a question that was to be pertinent for another two decades,

I should be obliged if you would advise on the following points:- (1) Ought one to refuse to meet in consultation a medical brother who is Medical Officer to a Medical Aid Association, and if one should refuse how does one's conduct differ from that of a trades-unionist who refuses to engage in work done side by side with a free labourer? (2) Ought such doctors to be allowed to belong to the various Branches of the BMA?

Robert Saundby, to be first Chairman of the CEC, proposed a list of matters for consideration by the committee:

Cheap Anonymous Dispensaries, Midwives, Pay Wards at Hospitals, Lack of Competent Assistants, Insecurity of Local Sanitary Arrangements, Inadequacy and Uncertainty of Retiring Pensions of Poor-Law Officers, Alteration of Memorandum of Association so as to permit Prosecution of Quacks, Bones Setters and Prescribing Chemists, Underselling for Public Appointments, Relations of Consultants to General Practitioners.

The committee also compiled a list of the ethical rules or declarations subscribed to by members of graduates of the various licensing bodies. It also surveyed each Branch of the Association as to

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56 Letter, in BMAA B/54/2/7.
57 See biography, p. 333.
58 GPC, 15.1.1895.
59 GPEC, 20.10.1896.
whether or not they had an ethical committee or other structures in place to deal with ethical questions. They found that 8 had Ethical Committees, that 9 used their Council for this purpose if the need arose, whilst 5 “declined to entertain the proposal to form an Ethical Committee”.60

This information seems to have been most useful to the GPEC, since from 1897 onwards it referred many ethical questions back to the appropriate Branch.61 They supported the resolutions of the ethical section, but could do little other than note their approval, and by 1899 the committee’s deliberations largely resulted in either taking no action, informing enquirers of resolutions passed, or expressing regret that nothing could be done.62 Some of the issues dealt with, and resolutions passed by this committee will be considered along with later material in later chapters.

New BMA: new “fighting machinery”

As we have seen, there was a long-standing tension within the BMA between the perceived need by many doctors, especially GPs, for a strong democratic organisation to defend and further their interests. The BMA had tended to be controlled, both centrally and locally, by “elite” or “leading” doctors and reluctant to pursue the problems most pressing on the “rank and file”. Bartrip describes “creeping dissatisfaction” growing though the last two decades of the nineteenth century.

Dissatisfaction with the BMA and to a lesser extent the GMC led to moves by a leading member of the Manchester Medical Guild, Samuel Crawshaw, to call a national meeting of local medical societies.63 The Medical Guild unlike other local societies had not been absorbed by the BMA as a Branch, and its main goal was the furtherance of the economic interests of GPs and with medical ethics. Other similar Guilds were springing up across the North. The proposed conference was to discuss the idea of organising GPs into a democratic representative body, with an annual meeting.64

This Conference took place on the 1st, 2nd and 3rd of May 1900. Among the 54 delegates representing 36 local medical organisations including the six branches and Council of the BMA were Cox, Smith Whittaker, and Victor Horsley.65 According to Cox, many

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60 Report of the GPEC, Council 8.7.1896. I can find no total figures for the number of Branches in 1896.
61 Meetings of the GPEC, 18.1.1897 and 13.4.1898 referred back half the questions addressed to them.
62 See GPEC 11.4.1899.
64 Bartrip, Themselves writ large, p. 143.
65 See biography, p. 335.

43
were in favour of a new body, a confederation of local medical societies devoted exclusively to medical politics and ethics, and a resolution to this effect was carried. ... I spoke as strongly as I could against the multiplication of organisations and moved ... that "every attempt should first be made to capture the BMA". There was strong opposition but I carried the day; Smith Whittaker of Great Yarmouth ... said that "he could not hope that the Association would ever reform itself". His proposition was that local medico-ethical societies and associations, and the new proposed annual conference be combined to make the BMA "an energetic body, really representative of the majority of the profession". The strategy succeeded, and a Committee including Cox and Smith Whittaker, was formed to approach the Association. Victor Horsley primed the BMA Council, and, at the BMA’s Annual Meeting in Ipswich proposed that a new constitution be drafted. The Constitution Committee elected for this task was made up of nominees of Council and an Extraordinary General Meeting and included Whittaker Smith, Cox, and Horsley. Its work proceeded comparatively smoothly and met with little resistance. The chief architects of its report were Whittaker and Horsley, and the new constitution was in place by 1902.

Perhaps the most important change was that the local units of the Association were made much smaller, with the introduction of a new unit, the Division, below the Branch. BMA members now automatically belonged to their local Division, and these were intended to "be such that every member thereof shall have reasonable opportunity of attending every important meeting." A local Division was envisaged as, amongst other things "a court of honour [enabling] a system of ethical conduct to be evolved", and this specifically in relation to contract posts under dispute, as well as other issues of conduct. Council, its members now largely elected by the Branches, remained the executive of the Association, but it was bound to follow resolutions passed by a 2/3 majority at the Annual Representative Meeting (ARM), which consisted of representatives selected by local Divisions. John McVail, who sat on the Constitution committee, and later on the GMC, specifically envisaged that this would allow local divisions to steer the Association’s policy on "political and ethical" issues. Despite the fact that the BMA was not officially a Trades Union, but rather a learned society, and a company limited by guarantee, Squire Sprigge was not simply employing a colourful metaphor when he described the new BMA as “a fine fighting machinery”.

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66 Cox, *Among the doctors*, pp. 74 - 6.
67 *ibid.*, p. 76.
68 Little, *History of the BMA*, 1932, p. 84.
69 *ibid.*, p. 234.
70 *ibid.*, p. 86.
Chapter 3

The Central Ethical Committee and the BMA after 1902

The New BMA

The BMA had now re-invented itself as “a federation of local medical societies called Divisions”.¹ These local societies defined Association policy through their representatives at the ARM. Thus whilst the Association’s committees were all officially committees of the Council, all their activities had to be approved by both bodies. Association’s business ran a three-cornered course between the ARM, Council, and Committees, all supported and co-ordinated by the secretariat. The strength of the system was the status conferred on decisions ratified by Council and by the ARM since both were representative of the membership. Carr Saunders and Wilson noted the distinction between the unrepresentative ‘rubber stamping’ Annual General Meetings held by most professional organisations and the BMA’s meetings. At ARMs they said, “every important issue is raised ... attendance is good, the debate ... keen”.² It would be a mistake, however, to see the “parliament” and “executive” as too distinct, or the “parliament” as too independent; the Council itself was unusually representative of the profession as a whole. It is also clear that many members of Council were also representatives at the ARM, and among these were several chairmen of the CEC.³

A great deal of communication occurred outside of these regular meetings, and the secretariat was of considerable importance. Letters addressed to “The Secretary, BMA” were often the way in which both members and the lay public contacted the organisation, and the Medical Secretary and his deputies were in constant contact with Honorary Division and Branch officials. This central secretariat, which grew steadily in size after 1902, along with the Council and the Organising Committee, were also able in various ways to influence the shape of ARMs through providing information, informing opinion, and advising behind the scenes. Despite this, as I shall demonstrate in later chapters, the ARM was quite capable of upsetting a policy prepared for its approval. Any division could introduce any motion it pleased and, if they caught the mood of the meeting, define policy. More generally, as Peter Bartrip has shown, the Representative Meetings created a great deal of trouble at times like 1911 - 12 and 1945 - 48.⁴

³ Arnold Lyndon, Reginald Langdon-Down and C O Hawthorne all fell into this category, see pp. 330, 329 and 328.
⁴ Bartrip, Peter, Themselves writ large, 1996, pp. 152 - 64, and 248 - 66,
The functions and constitution of the CEC

The Ethical Committee formed in 1902 was initially one selected by Council, but after the first ARM of 1902, it consisted of six members nominated by Council, six members nominated by the ARM, and had four *ex-officio* members. These were the President of the Association, the Chair of Representative Meetings, the Chair of Council, and the Treasurer. Occasionally *ex-officio* members would take part in the CEC’s work, but this was rarely for a sustained period. The committee members elected a Chairman each year from among their number, and these chairmen usually served for many years consecutively.

The duties of the Ethical Committee as formally described by Council in 1903 were:

- To consider and advise the Council upon all rules of Branches and Divisions relating to ethical matters
- To report to the Council on the conduct of individual members where this was to be considered by the Council
- To arbitrate between members when so desired
- To act generally under the Council in reference to all matters of professional conduct.

The first of these functions reflected the “Central” nature of the CEC; each Division and Branch could act as an independent ethical tribunal under the new constitution, and the CEC’s role was to act as an advisory body to them. The second function entailed the Committee in deciding whether to recommend the expulsion of members when this was requested by a Branch Council. The third function, as an arbitration service between doctors in dispute, provided something which until this point no national medical organisation had been willing to tackle. It was to be a small part of the committee’s work, but judging by the documents these cases generated, amongst the most trying. The last function was a catch-all which entailed the Committee in a good deal of work in terms of writing reports on difficult ethical issues, and considering matters that no other part of the organisation could take up. It is with this latter area of work that this thesis has been most concerned.

This set of functions forms a marked contrast to the mid-nineteenth century ethical committees, which had both been set up to write a code of medical ethics, and the rather vague remit of the GPEC. The production of a code was never an official function of the Committee, and no such

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5 Council, July 1903, in BMAA B/54/2/11.
6 A great deal more will detail on this area in chapter 6.
document was published until 1949. It is clear that the Association looked to the Committee for two main things, the adjudication of individual cases of offending or disputed conduct, and the clarification of specific issues, either in the form of rules or regulations, or in the form of resolutions, then adopted by the Association. Cox's description of the Committee's work was usefully broad but exact; it being its "duty ... to maintain the right standard of professional conduct and deal gently but firmly with erring ones".

Pattern of CEC work

Meetings of the CEC were usually scheduled to start after lunch at 2:30, but there is no indication in the minutes of how long they lasted. It is hard to imagine they were short, for each meeting there were large numbers of documents to be read on a number of complex issues and cases.

The committee quickly became very busy; it met six times in 1902-3, and seven times the following session. A total of ten meetings were held in 1905-06, and it was during this session that it was decided to introduce a Standing Ethical Subcommittee (CEC s/c) to meet between CEC meetings at short notice to consider urgent matters. The subcommittee was composed of the Chairman and members of the Committee who lived in or near London (effectively those able to come at short notice), and usually met in each month in which the CEC itself did not meet. The BMA sessions quickly settled into a rhythm. Each started in October and culminated in the ARM in July, with a three-month quietus following it. In most years the CEC met 4 times, timed to precede the quarterly meetings of Council, and the subcommittee usually met 5 times in between. This arrangement fluctuated from time to time; the subcommittee started by meeting only twice to the main Committee's eight in 1905-6. The next year it met eight times and the CEC four times.

Quite how the committee functioned as a group we can only guess. There were only a few occasions on which differences of opinion, or prolonged discussion were recorded in the minutes, but many more where it was evidently difficult to reach a decision quickly. A number of these are described in the following chapters, but quite what form discussions took is sadly a matter of conjecture.

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8 BMA, Ethics ... of the Medical profession, 1949.
9 Cox, Among the doctors, p. 106.
10 CEC s/c, 4.5.1906.
Membership and Chairmanship

A search of the CEC minutes from 1902 to 1939 identified 75 doctors who served on the CEC, excluding those who attended *ex-officio*. Most of these members are of little interest, since a large minority of them attended few meetings, or served only for short periods. Out of the total of 75, 17 members served for only one year, 18 served for 2 or 3 years. Overall, 46% of those elected to the committee served for 3 years or less, 31% served for between 4 and 9 years, and 23% served for 10 years or more. This latter group put in 49% of the total ‘member-years’. Members were usually very conscientious in attending meetings and those whose attendance was poor tended to be the same members who were not elected for a second year. The only point at which attendance became more generally patchy generally was in the session 1912 - 13 directly following the National Insurance crisis. The chairman Lauriston E Shaw had resigned in the middle of the previous session feeling that other members of the BMA did not tolerate his pro-Insurance sympathies.

The poor attendance here was reflected in a falling membership of the BMA in the years that followed.

On the other hand a small number of members contributed disproportionately to the CEC’s work, as measured by attendance. In the following section I shall describe what is known of those who served for 5 years or more, 10 years or more, and the Committee’s chairmen. The CEC had only three female members during this period, only one served for more than 5 years. Dr Elizabeth Casson served for one year only in 1933 - 34, and Dame Louise McIlroy served for one year in 1938 - 39. Christine Murrell was already a member of Council, when she joined the CEC in 1924 - 25. She went on to be elected as a direct representative to the GMC, the first woman to be elected to this body, but tragically died only a few months later.

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11 The figures given in this section have been abstracted from a comprehensive list of names, and dates of meetings covering the period 1902 - 1939, made up from the BMAA committee minute books. It is a very long document, and thus has not been included in the thesis.

12 See biography, p. 334.


14 Christine Murrell (1874 - 1933) was educated at Clapham High School for Girls and the London School of Medicine for Women. After working as a house officer and medical registrar at Royal Free, and resident Clinical Assistant at Northumberland County Asylum at Morpeth she went into general practice in London “with special attention” to neurological and psychological problems. She was on the Council of the BMA from 1924, was President of the Metropolitan Counties Branch in 1928, and was President of the Women’s Medical Federation 1926 - 1928 as well as serving on the Council of the MDU. A staunch but unpartisan proponent of general practice and women’s place in medicine she was said to be “forceful and tenacious in argument, concise and direct in speech” and “amongst the most successful general practitioners in London”.

The core of long-serving members

There were 17 members who served for ten years or more, and one, Reginald Langdon-Down, had served for thirty-four when the outbreak of war froze routine BMA business in 1939. This achievement is the more remarkable for the fact that Langdon-Down served on the subcommittee from its inception and thus he would have attended over 300 meetings of the Committee stretching over four decades. He also attended most of the ARMs and most Council meetings during this period. Three of long-serving these members died whilst still on the committee. The following table is a graphical representation of the way in which their terms of membership overlapped. It is particularly striking that by the end of the 1930s a large minority on both the Committee and the sub-committee were “long-servers”. At the outbreak of the Second World War 7 out of 12 members of the CEC had already served more than ten years, including three past chairmen. Those indicated in the bold type have biographies in the biographical appendix, and all appear in either of the two prosopographical sections which follow.

Table 1: members of the CEC serving 10 years or more

Biographies of the members given in bold appear in Appendix A.

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Key: | Secretary to CEC |
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See biography, p. 329.

Sources, successive CEC minutes (BMAA) and some additional information from obituaries (see Appendix A).

49
Prosopography of members serving 5 years or more

Taking service of 5 years or more on the committee as a cut off for "significant" contribution to the work of the CEC, including ex-officio members who consistently attended, but excluding chairmen, 28 members fall into this category. Information on type of practice, years since primary qualification on joining the committee, location of practice, and qualification have been collected and tabulated. A number of points emerge from this analysis. The committee's longer serving members were an even mix of "pure" GPs, "pure" consultants, and doctors whose practice was mixed. However, physicians were rarely involved, most of the "specialist" components to these doctor's practices being either general surgery, or specialities such as obstetrics, gynaecology, ENT or ophthalmology. Another feature that emerges strongly is the moderate level of qualification of these doctors. I have allocated qualifications to four main groups, the first level being basic licensing qualifications. 6 members had only these basic Conjoint qualifications of MRCS LRCP (or equivalent). The highest qualification of a further 4 was the basic "pair" of university bachelor of medicine and surgery degrees (MB, BS, ChB, etc). I have put MD or MA degrees in a higher category, and a further 7 members had an MD as their highest degree. Of those in the fourth category, with higher collegiate degrees the majority, 8, were FRCS, and whilst none were MRCP, one member was FRCP(Edin.). There were two strong trends. Firstly, a clear majority had passed their basic qualifications 30 years or more before joining the committee, with only 3 having spent 20 years or less in practice before joining. Secondly the CEC was overwhelmingly English, with London and the South of England being strongly represented. This may simply reflect two basic facts of distribution and logistics. Most doctors in the British Isles were in practice in England, and a large number of those practised in or near London. Members of the committee with shorter distances to travel would, it is reasonable to assume, have found the journeys less inconvenient to make.

Thus, if we were to create a picture of a typical longer-serving member of the CEC who was not a chairman at any time, he would be a moderately well qualified general practitioner with a surgical appointment at a local hospital, in his sixties, living close to or in London. Most of these men would have received their general and medical education in the last third of the nineteenth century. It seems likely that it was a mixture of age, experience, and security in practice (both economic and medical) that enabled these men to stand, and to be chosen by the ARM and Council.

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1This information has been collected from Medical Directory entries for the period at which the member left the committee, along with some information gleaned from obituaries (see Appendix A).
Table 2: Qualifications and other details of those who served 5 sessions or more on the CEC-1902 - 1939 (excluding Chairmen)

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<td>OBE / MBE</td>
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Notes:
- Discipline has been hard to ascertain in some cases
- Years in practice is usually calculated from the years elapsed since first qualification
- Location is given as L=London, P=English provinces, W=Wales, S=Scotland, I=Ireland

Information abstracted from successive Minute books of the CEC (BMAA), and collated with Medical Directory entries for the period at which the member left the committee, along with some information gleaned from obituaries.
Table 3: years since primary qualification at time of joining

<table>
<thead>
<tr>
<th>years in practice</th>
<th>number of members</th>
</tr>
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<tbody>
<tr>
<td>less than 10</td>
<td>0</td>
</tr>
<tr>
<td>10 - 19</td>
<td>3</td>
</tr>
<tr>
<td>20 - 29</td>
<td>10</td>
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<tr>
<td>30 or more</td>
<td>15</td>
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Table 4: members analysed by type of practice

<table>
<thead>
<tr>
<th>type of practice</th>
<th>number of members</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP only</td>
<td>9</td>
</tr>
<tr>
<td>mixed</td>
<td>10</td>
</tr>
<tr>
<td>Consultant only</td>
<td>9</td>
</tr>
</tbody>
</table>

Table 5: members analysed by location of practice

<table>
<thead>
<tr>
<th>location</th>
<th>number of members</th>
</tr>
</thead>
<tbody>
<tr>
<td>London</td>
<td>10</td>
</tr>
<tr>
<td>English Provinces</td>
<td>16</td>
</tr>
<tr>
<td>Wales</td>
<td>0</td>
</tr>
<tr>
<td>Scotland</td>
<td>1</td>
</tr>
<tr>
<td>Ireland</td>
<td>1</td>
</tr>
</tbody>
</table>

Names of doctors listed in these tables
(those in **bold** have biographies in Appendix A)

1. **Dr A G Bateman** (Queen Anne St, W)
2. Dr H A Ballance (Norwich)
3. Mr C R Stratton (Wilton, nr Salisbury)
4. Dr Edwin Rayner (Stockport) JP
5. Dr Philip G Lee (Cork)
6. Mr J H Ewart (Eastbourne)
7. Dr C H Milburn (Hull)
8. **Dr James Neal** (Birmingham and Golders Green)
9. Dr J Wishart Kerr (Cambuslang, nr Glasgow)
10. Dr Milner M Moore (Eastbourne)
11. Mr E B Turner
12. Mr J Furneaux Jordan (Birmingham)
13. Capt John Orton (Coventry)
14. Dr H C Mactier (Wolverhampton)
15. Dr H C Bristowe (Wrinton Somerset)
16. Dr John Stevens (Edinburgh)
17. Dr E W G Masterman (Camberwell)
18. Dr P Macdonald (York)
19. Dr Christine Murrell (London)
20. Dr J F Walker (Southend on Sea)
21. Dr L A Parry (Hove)
22. **Mr N Bishop Harman** (London)
23. Dr J Hudson (Newcastle upon Tyne)
24. Dr E Welch (Leeds)
25. Dr H L Hatch (Pinner)
26. Dr L Kilroe (Rochdale)
27. Dr P B Spurgin (London)
28. **Dr R Forbes** (London)
Chairmen of the CEC

Obituaries of those involved with the CEC often stress the “delicate” or “difficult” nature of the work involved, and this is particularly true of those who chaired the Committee. The Chairman often had to act on difficult cases or authorise Notices between meetings. They also had the important job of presenting Reports and draft resolutions to Council (of which all were members, at least at the time of their chairmanship) and the ARM.

I have provided biographies for all these men, in Appendix A, but have also set out their terms of office, vital dates, qualifications and a brief sketch of their medical work in table form. It is worth comparing them as a group with the group of longer serving members. In the first eleven years of the Committee’s work it had 4 chairmen, all of whom were consultants, and although Kinsey was not a particularly eminent man, the others were either reasonably prominent, or were in the process of becoming so. This was in marked contrast with the rest of the period, in which the CEC’s chairmen resembled its members much more closely. They were GP surgeons, with two exceptions. Langdon-Down inherited a hugely successful Home for the mentally handicapped, and appears to have developed some West End practice out of this, whilst Hawthorne was a prominent West End practitioner with a clutch of minor consulting physician posts. As an overall trend then, the chairmanship of the CEC was ‘downwardly mobile’. This may well not represent any falling off of status for the Committee during this period. It is more likely that it reflects a growing confidence in the work and experience of those involved in it, particularly since after 1920 the chairmen were all drawn from the ranks of the longest serving members.

The chairmen of the Committee were representative of the sorts of doctors who could afford to engage in significant amounts of medico-political work. It could be argued that the Chairmanship of the CEC was skewed in favour of consultants (6 out of 9) as opposed to general practitioners, but caution should be exercised in reading too much into this. By far the great majority of GP’s would have found it impossible to find enough time to serve on the Committee, let alone chair it.
Table 6: Chairmen of the CEC 1902 - 48
(Full biographies of each of these are given in the Biographical Appendix.)

<table>
<thead>
<tr>
<th>Years</th>
<th>Name</th>
<th>Biographical Notes</th>
</tr>
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<tbody>
<tr>
<td>1902 - 1905</td>
<td>Prof. Robert Saundby</td>
<td>(1849 - 1918) MB CM MD FRCP Consultant academic physician, in Birmingham, medical politician, and author of <em>Medical Ethics</em></td>
</tr>
<tr>
<td>1905 - 1909</td>
<td>Mr Robert H Kinsey</td>
<td>(?)1842 - ? MRCS LSA JP Consultant Surgeon to Bedford County Hospital</td>
</tr>
<tr>
<td>1909 - 1910</td>
<td>Dr (Sir) Ewan J Maclean</td>
<td>(1865 - 1953) MB CM MD FRCP JP Consultant Gynaecologist to Cardiff Infirmary, and early president of the Royal College of Obstetrics and Gynaecology</td>
</tr>
<tr>
<td>1910 - 1913</td>
<td>Dr Lauriston E Shaw</td>
<td>(1859 - 1923) MB MD MRCS FRCP Consultant Physician to Guys, Dean of the Medical School, proponent of State medicine and National Insurance.</td>
</tr>
<tr>
<td>1913 - 1919</td>
<td>Dr Moses Biggs</td>
<td>(c1867 – 1935) MRCS LSA MD General Practitioner and Surgeon to the Battersea Dispensary</td>
</tr>
<tr>
<td>1919 - 1926</td>
<td>Dr Reginald Langdon-Down</td>
<td>(1866 - 1955) MA MB BC MRCP Inheritor of a thriving Home for mental defectives, with modest West End practice in childhood and mental problems.</td>
</tr>
<tr>
<td>1926 - 1933</td>
<td>Dr Arnold Lyndon</td>
<td>(c1861 - 1946) LSA MRCS MB MD OBE Surrey GP and surgeon</td>
</tr>
<tr>
<td>1933 - 1935</td>
<td>Dr Charles O Hawthorne</td>
<td>(1858 - 1949) MB CM MD FRFPS FRCP Glasgow academic physician, later moved to London and West End consulting practice</td>
</tr>
<tr>
<td>1935 - (1948+)</td>
<td>Dr Noel Waterfield</td>
<td>(c1877 - 1960) MB BS LRCP FRCS Surrey GP and Surgeon</td>
</tr>
</tbody>
</table>
Other personnel

The Committee was usually served by the Deputy Medical Secretary of the time, who would also have been present, but whose names appear on none of the minutes. Deputy Medical Secretaries who served the CEC included Alfred Cox, George Anderson, both of whom went on to be Medical Secretaries of the BMA (a position of considerable importance and influence), James Neal and Robert Forbes, both of whom went on to be Secretary of the Medical Defence Union.\(^{18}\) Thus the CEC’s secretaries tended to be men of some ability, destined for higher office. It has not been possible to ascertain how active they were generally in taking part in, or shaping the Committee’s work. They were certainly important as drafters of documents on issues being worked up by the Committee. When cases or issues involving legal risk to the Association, or requiring an intimate knowledge of the legalities of its constitution, the BMA’s Solicitors William Hempson or his son Oswald, would attend at the CEC. Hempsons were also the Solicitors to the MDU, the firm having been chosen by the BMA in the light of the work done for the Union.\(^{19}\)

The CEC in the context of the BMA

This section is a synthesis of the reading of primary archive materials for this research and is intended to give an overall impression of the committee’s activity. I have not footnoted each type of activity since instances are fully footnoted in successive chapters.

Presenting a problem to the CEC

Matters for consideration came from many sources. Enquiries from members of the public or medical non-members that the Secretariat could not handle directly were often referred to the CEC if a conduct issue was involved. If the enquiries involved a “case”, that is a dispute between doctors, or an alleged breach of received ethical norms, they almost always referred back by the Secretariat or the Committee to the local Division level in the first instance. If the Division had not been able to reach a decision, they could refer problems back via their Branch, to the CEC. Officially the Council was the Association’s “highest court”, but in practice this function was delegated down to the CEC,\(^ {20}\) since full Council meetings were expensive to arrange.\(^ {21}\) Branches could also request the expulsion of a member from the Association, and in fact the central organisation had no power to request this of its own accord. In this situation the CEC would

\(^{18}\) Their biographies appear on pp. 339 (Neal) and 332 (Forbes).
\(^{19}\) Br. med. J., 1919, i: 504
\(^{20}\) ARM, 1905.
\(^{21}\) CEC, 23.10.1914.
consider the case and make a recommendation to Council, which would decide whether or not expulsion was warranted. (The issue of whether or not the Association could or should refer cases to the GMC was never resolved, and is the subject of a later discussion.) General questions were almost always referred to the CEC via Council by a motion of the ARM, although other committees might ask for their opinion on matters connected with their own work.

Communicating the decisions and opinions of the CEC

There were, in theory, a large number of ways in which members of the BMA could learn of the outcome of matters referred to the Committee. It is difficult to know the extent to which the information available was actually used by members except in cases where the CEC communicated directly with them. The quarterly and annual reports of the Committees were reproduced in the *Supplement* to the *BMJ*, as were Council and ARM discussions of them. These only mentioned details of specific cases (and never names) when expulsion from the Association was contemplated. The *supplement* was only sent to members of the BMA and thus allowed the Association to disseminate its "intelligence" with a degree of privacy. Communication of Reports and sets of rules was much more rigorously pursued, although, once again, it was up to the individual member in most cases to learn what they were. Draft reports and rules were circulated in the *supplement* before the ARM debated them, and final versions also appeared there, and were available as offprints. These offprints appear to have been provided mainly for the use of local officers, who could distribute them as they saw fit.

ARM ratified decisions of the Association, among them a number of "ethical" resolutions, were also reproduced in a series of yearly *Handbooks* and *Yearbooks* that were produced from 1905 onwards. These also contained lists of names of committee members, honorary officials, including those of the Divisions, calendars of events and the memorandum and by-laws of the Association. These *Handbooks* and *Yearbooks* again appear to have been distributed primarily to Branch, Division and Central officials.

Resisting codification

Although the general publication of a dedicated code of ethics had to wait until 1949, there was consistent interest in the production of a digest or guide from the inception of the CEC. The CEC

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22 From 1904 - 1906 they were *Yearbooks*, see BMAA series B/55/15/1 etc, after 1920 they were *Handbooks*, see BMAA B/55/16/1 etc, reverting to *Yearbooks* again in 1951.

23 Memorandum, Medical Students s/c (MS s/c), 27.9.1934. Around 800 copies of the *Handbook* were printed each year.
resisted these requests consistently although the Secretariat did include ethical guidance in the
Association’s *Handbooks for Newly Qualified Practitioners*, from 1923.

Early plans to produce a digest of the decisions of the committee never came directly to fruition. A code or digest of the committee’s decisions was requested in 1915, but the committee decided that “it was not desirable to formulate an ethical code”. In 1920 the CEC received a request from the Australian Federal Committee of the Association for a digest of anonymised case reports of the CEC for their guidance. The Committee decided that

such a report would be dangerous and misleading. ... it was pointed out that the minutes of the Committee merely recorded the concrete decisions; that important points often came out in the discussion which had a material bearing on the conclusions arrived at; that without an indication of these points, of which the committee found it impossible to incorporate in any *précis*, such a *précis* would not be helpful, but the reverse

In 1922 a request from a member for “a circular or pamphlet, containing a few striking examples of the pit-falls that beset practitioners in ethical matters” was refused. Other parts of the organisation were not so reticent; the South Africa Committee had drawn up a “Guide to medical ethics” in 1924, which consisted of 50 pages of short decisions and rules. A *BMJ* review stated that it was “dogmatic” and took “short cuts taken through thorny issues” but “generally a useful *vade mecum*.”

Closer to home, the secretariat and the Medical Students subcommittee (MS s/c) of the Organising Committee (OC) had produced the first *Handbook for Newly Qualified Practitioners*, which included a section on medical ethics, without referring to the CEC at all. This strange split was possible because the Secretariat kept a “typescript book” containing the CEC’s decisions on different questions under different headings. This enabled the medical secretaries to respond

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24 CEC 18.12.1903, BMAA B54/2/11, mentions the preparation of a “Guide”, but there is no evidence in the minutes thereafter. The 1906 *Yearbook*, p. 80, mentions “a small code of rules was compiled early in 1904 from those which had already received the approval of the ... Council”. No such guide or code was produced however, but I have not been able to find any discussion as to why this particular scheme was dropped. According to *Br. med. J.*, 1908 II: *supplement*, 1.8.1908, p. 127, Kinsey undertook to produce and epitome of decisions, but once again, no trace of this undertaking had been found.

25 Memorandum, CEC s/c, 20.2.1924.

26 ibid.

27 CEC s/c, 6.12.1922.

directly to enquiries from outside. However, a section on “Duties” in the first Handbook, appears to have been a spontaneous piece of work, and it is striking that it was discontinued.

The idea for this handbook had arisen out of a Conference for Medical Students held in 1921. Dr J C Matthews, Dean of Liverpool University, spoke of the need for “something in the nature of a handbook” since lectures were of “little value” and “the most important time to get at the student was immediately after he qualified”. From the start the proposed handbook was seen as an important recruiting tool to be used at meetings of the newly qualified at which they were invited to join the Association. The initial draft was a modest little information booklet but it was decided to make the handbook more ambitious with the inclusion of “business and ethics” topics, and short articles on the main careers open to doctors.

The first Handbook appeared in 1923 and included a section entitled “the Duties of Medical Practitioners”, which was almost certainly written by a Deputy Medical Secretary named McPherson, and a legal section written by W A Brend. The ethics section was brief and general, and included the Hippocratic Oath, and is considered in chapter 5. The Handbook was a great success; roughly 2000 copies were distributed each year and there was constant pressure to broaden its scope and its distribution and it was renamed The Medical Practitioner’s Handbook for its 1935 edition. The editions of 1926 and 1935 combined the ethical and legal advice into a single section on “The practical aspects of medical practice”, after the opinions of Langdon-Down and Brend were sought, although the CEC itself continued to have nothing to do with its production.

The CEC kept up this resistance until 1938, when the Association was approached by the Board of Deputies of British Jews with a request that the BMA to supply material for a pamphlet code of ethics in English and German for refugee medical practitioners. The British Dental Association had BDA had produced one which was now in press, and the CEC recommended co-operating with

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29 Minutes, Conference to Medical Students, 1.12.1921, in CMAC SA BMA A17.
30 MS s/c 16.5.1922, Council 25.10.1922.
31 Organising Committee (OC), 2.10.1922.
32 Council agenda, 9.6.1926.
34 MS s/c, 25.9.1923.
this project.\textsuperscript{36} However, after the Second World War the committee itself decided to publish a short code, and this is discussed at much greater length in Chapter 14.

**Summary**

The CEC was elected by Council and the ARM and developed a core of long-serving members by the 1920s and 1930s, typical members being experienced doctors of middling qualification and status. It was an important part of the BMA central structure and had the dual role of handling of "cases", and formulating ethical rules or reports for the Association. This latter function was, as the following chapters will show, often a difficult and contested process. The Committee resisted calls to produce a general code of medical ethics until the end of the period with which this study deals, and then did so only in special circumstances.

\textsuperscript{36} Council, 18.1.1939.
Chapter 4

The CEC in context: other organisations

Introduction

The conduct of doctors was a concern of all medical organisations at this time, and indeed this remains so to a certain extent today. The purpose of this chapter is to describe a number of the other medical bodies involved in conduct and ethics issues, and to draw out differences, similarities and links with the BMA. The choice of the Royal College of Physicians of London, the GMC, and MDU has been made for a number of reasons. Not least among these is the availability of works describing these bodies and their histories. For instance, Sir Zachary Cope’s history of the Royal College of Surgeons is extremely uninformative on medical ethics and politics. Indeed the most useful information I have found on this organisation has been in the minutes of the OPEC. Another has been to choose one of each of a number of types of organisation. Lastly, there were particularly strong historical links between the GMC, BMA and MDU. The BMA had interested itself in reform from the outset and was instrumental in keeping up pressure on successive Governments to legislate. The GMC was the body set up as a result of this pressure. The impetus to set up the MDU came partly out of the perceived lack of effective medico-political muscle on the part of the GMC, (and to some extent the BMA). The Union made it its business to push, along with the BMA, for further reforms to the statutory regulation of medicine. These links are such that it has been difficult to arrange the material for the chapter in a linear sequence.

The older medical corporations by contrast, were elite bodies, primarily concerned to protect the status and privileges of their Members and Fellows drawn from particular parts of the profession, and from particular parts of the UK. As relatively ancient bodies with Royal Charters their influence over their rank and file members was exercised in a more hierarchical manner, but still addressed similar issues and pressures facing doctors. Furthermore it can be argued that, all criticism aside, these Colleges formed an important ‘cultural template’ for the more modern medical organisations, and their notions of association, exclusion and conduct.

Particular standards of conduct were expected of the members of all these organisations, and formed part of the definition and boundaries of each specific group, although these boundaries and those of the profession as a whole were often closely related.

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The Royal College of Physicians of London

The origins and development of the College

The Royal College of Physicians of London was established under a Charter of Henry VIII of 1518 in order “to check men who profess physic rather from avarice than in good faith, to the damage of credulous people”. It limited the practice of Physic in London and 6 miles around to those who had qualified in medicine from the Universities of Oxford and Cambridge, or continental Universities, and who took the College Oath. It also gave the College power to inspect apothecaries and destroy any sub-standard medicines found in their shops, to publish a Pharmacopoeia, and placed physicians as superior in knowledge to surgeons. It was governed by meetings of its Fellows, known as Comitia, and 4 Fellows were appointed each year to oversee disciplinary matters and inspect apothecaries. The College was for a great many years a small elite organisation irrelevant to the majority of practitioners of medicine or surgery in the rest of England, and had a tiny membership until later in the nineteenth century.

Describing the College in the 1830s, Cooke stated that “inside the profession it was known mainly as an examining body of oligarchical structure”. He went on, “despite minor modifications, the governance of the College had changed in no major essential from the time of the foundation. We can only speculate on the Fellows’ conception of the functions of the College”. By the mid-nineteenth century a strict three tier structure existed. Although Members could become Fellows, they had few privileges, aside from the status conferred by the qualification, whilst Licentiates were simply diplomates of the College with no power whatsoever. The Fellows numbered only 188 in 1858.

The disciplinary functions of the College

From its foundation the College’s Statutes placed Fellows under an obligation towards their colleagues, and set out fines for such offences as refusing office, and failure to attend Comitia or the funerals of Fellows. The original statutes set out a number of fines relating to offending behaviour in relation to other Fellows and their patients; such as failing to ascertain previous treatment, “bad


ibid., pp. 865 - 6.
manners at consultation” and “consultation with an empiric”.5 The Censors Board, elected annually from among the Fellows, was charged with “the supervision and control, correction and government of all and every physician [in London]”. This group effectively carried out the College’s punitive and investigative functions in respect of Members, Fellows and Apothecaries, and could invoke a range of sanctions including fines, and imprisonment, under the Statutes.6 In the 1880s and afterward the Board also had responsibility for admitting Members and Licentiates, although it is not clear when it acquired this function.7

The Bye-laws of the College set out in great detail the running of its business and the behaviour of its members and officers. Fellows, Members and Licentiates swore to uphold these, and “to do everything, in the practice of your profession, to the honour of the College and the welfare of the State”.8 Only those “who are distinguished by character and learning” were to be admitted Fellows, and even Licentiates had to be “of moral character”.9 The Fellows and Members were debarred from suing for fees, engaging in trade, dispensing medicines, compounding medicines for any but their own patients, and from financial arrangements with apothecaries, druggists etc. They were debarred from refusing to make known to other members the composition of remedies in their use, but also from the revelation of any of the College’s business and secrets.10 The general disciplinary Bye-law of the College stated that

If it shall ... appear ... or be made known to the President and Censors ... that any Fellow, Member or Licentiate has been guilty of any great crime or public immorality, or has acted in any respect in a dishonourable or unprofessional manner, or has violated any [College rules] ... the President and Censors may call the [F M or L], so offending, before the Censors board, and having investigated the case, may admonish, or reprimand, or inflict a fine not exceeding £10; or ... they may report the case to the College, and thereupon a majority of 2/3 ... may declare the [F M or L] no longer a [F M or L].11

Thus any member of the college who was found by the Censors to have behaved in a way of which they disapproved could be voted out of the College by a majority of the Fellows in Comitia. In the nineteenth and early twentieth centuries the College added a series of resolutions on matters such as

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6 ibid, p. 92.
7 ibid, p. 874
8 RCP Bye-law XXI.i, from The Charter, Bye-Laws and Regulation of the RCP, 1862.
9 RCP Bye-laws XX.i and XXI.i, in ibid.
10 RCP Bye-law XXIII, sections i, v, viii, vi and ii, in ibid.
11 RCP Bye-law XXIII.x, in ibid.
advertising, involvement in therapeutic businesses, behaviour in consultation and so forth. These resolutions will be dealt with in subsequent chapters.

**The Composition of the Censors Board 1902 - 1939**

Whilst it is outside the scope of the present study to look in detail at the business of the Censors Board, I have compiled a list of those who served in this capacity during the years with which we are primarily interested. A number of points have emerged from this survey. Firstly few names of Censors Board members appear familiar as doctors involved in the BMA, the notable exceptions being Sir Thomas Clifford Allbutt and Lord Dawson, both of whom were Presidents of the Association at one time. Another notable name was that of Norman Moore, Censor in 1905 - 1906, 1st censor in 1909 and President of the College 1919 - 1922, who was also a long serving member of the GMC. No Censors ever served on the CEC. Indeed Langdon-Down resigned his Membership of the College in 1925 on their recommendation, in an episode to which I shall return later. Few served more than 2 or 3 years, and those who did serve for longer periods of time never did so continuously. It is clear that service as a Censor was a stepping stone to Presidency of the College, and it was only as Presidents, or as Registrars, that Fellows served for over 2 years in total on the Board.

Cooke has given some indication of the activities of the Board. In the 1870s it acted as an arbitrator between two fellows. In the 1900s they had to discipline Licentiates for using the styling "doctor", one Fellow for acting as a general practitioner, and another for a newspaper article on "the Cheese Dinner". In the 1920s the Board disciplined members for selling a practice, advertising, and for improper certification, but was said to be less busy than it had been hitherto.

The College was therefore a body dedicated to its own status and honour, and the control of inferior grades of practitioners. It chose its membership on the basis of qualification and character, and exercised disciplinary control over them by the mechanism of enquiry first before a special group of

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12 As with the list of CEC members, this has not been included here, since it is very long. It was abstracted from RCP, *Lists*, 1902 - 1938.
13 See biography, p. 324.
15 Sir William Gull and Dr. George Johnson were in dispute over a case of poisoning. Cooke, *A history of the RCP*, (Vol. 3), pp. 830 - 1.
16 *ibid.*, p. 997.
17 *ibid.*, p. 1035.
senior Fellows, the Censors Board, and if necessary before a full meeting of the Fellows. The sanctions for breaching the rules of the organisation or for any behaviour judged to be disreputable included fines and imprisonment, under the terms of the statute, but the key punishment was exclusion from the College. Power and influence remained in the hands of the Fellows, although by the mid-nineteenth century the College had a large number of powerless Licentiates who were usually general practitioners. Their number was increased by the success of the Conjoint Board under which huge numbers of ordinary doctors qualified as LRCP and MRCS after the mid 1880s.

The Royal College of Surgeons of England

The College evolved out of the mediaeval Company of Barbers which was incorporated in 1462 as the Guild of Surgeons. In 1540 it became the Company of Barber-Surgeons, in 1745 the Company of Surgeons, and finally the Royal College of Surgeons of London in 1800. The College was self-elected, and those on its Council served for life. Its membership examination was used in the nineteenth century as a general practice qualification of around the standard of the Licentiate of the Society of Apothecaries. In 1843 the College became the RCS of England, and the Fellowship was introduced to extend electorate and mark out good teachers.18

There was little in the College bye-laws to restrict the activities of its diplomates and members, although it did have some broader disciplinary machinery. Cope gives an isolated example of a Taunton pastry cook who had passed the Membership exam having given false credentials who was stripped of his diploma in 1845. On becoming Members or Fellows surgeons were asked to swear an oath to abide by the bye-laws and to "demean themselves honourably in the practice of [their] profession and to the utmost of [their] power maintain the dignity and welfare of the college".19 Further sections bound members to behave properly within the College buildings and not to obstruct or disrupt the appointed business of any of its meetings.20 The ultimate sanction was the removal of the surgeon from Fellowship or Membership, which the Council of the College was able to do if it judged "after due enquiry" that the surgeon had "been guilty of disgraceful conduct in any professional respect".21 Here once again we see a basic set of ideas, the obligation to the status of the group, and the sanction of removal from it for any disgraceful or disruptive behaviour.

18 This potted history is a digest of Cope, The RCS: a history, 1959.
19 Section XIV of the Bye-laws of the RCS, in GPEC, 20.10.1896
20 Section XVII
21 Section XII
The General Medical Council

The GMC as the body that defines the orthodox medical profession in the UK has been an object of fairly stringent criticism, it appears, from its earliest days up to the present. It is the meeting point for numerous social forces; not only overseeing the relationship between the profession and the public, but also uniting the different parts of the profession. Given this, it is sad that a thoroughgoing history of the Council remains to be written. Two works of good quality have recently been published, but both have had an overwhelming focus on the present and very recent past. Neither book deals much with the Council’s educational regulation, although we are not concerned with that here. Russell Smith’s study is primarily an appraisal of the GMC as a judicial body, and his analysis is primarily legalistic and tackles basic questions of jurisjudicial competence. Margaret Stacey’s gaze was rather wider, being concerned with the whole way in which the Council negotiated the power of the profession in the face of growing pressure from within the profession in the 1970s and from the rise of consumer rights in the 1980s. Much of the section that follows has been compiled from primary source materials and related secondary sources.

The constitution of the GMC and the Medical Acts

The statutory purpose of the General Council for Medical Registration and Education was to enable the public to distinguish the qualified from the unqualified medical practitioner. The tools to achieve this were to control entry into its Register by qualification from University courses, and College examinations, and to remove from the Register those guilty of “infamous conduct in a professional respect”. The Council was composed of representatives of the Universities and licensing corporations and a number of nominees of the Privy Council, to which it was answerable. According to Carr-Saunders and Wilson it took the Council 20 years to ‘get into its stride’ and 30 to be able to assert its authority with the licensing bodies, and this is borne out in other sources. It appears that, at least to start with, the Council acted as a new arena in which the various Colleges and other bodies could continue their squabbles. The Council had to contend with

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26 ibid, p. 86.
the various precedents, rights and privileges of the examining bodies without well defined powers and structures of its own. Even basic functions - establishing a register, and publishing a Pharmacopoeia - took 3 and 6 years respectively to accomplish.27

The sections of the 1858 Act with which we are most concerned are Section 29: which allowed erasure from the Register, Section 40: which allowed the prosecution of anyone falsely describing themselves as a registered medical practitioner, and Section 32: which allowed registered medical practitioners to sue for fees.28 Amending Acts were passed in 1862, incorporating the Council, in 1876 allowing the Registration of either sex. The Medical Acts of 1886 increased Scottish University representation, introduced Direct Representatives elected by those on the Register, and also stipulated that registration now required qualification in Medicine, Surgery and Midwifery.29 Under this new regime the RCP and RCS introduced the Conjoint MRCS LRCP examination system. The Council also grew in size as more Universities were incorporated, such that the growth in University representation (9 more members in 1939 than in 1858) always more than kept pace with the growth in direct representation of the profession (5 granted in 1886 and increased to 7 by 1939). Whilst only the representatives of the Corporations had to be doctors, no lay person was selected to serve on the GMC until 1926.

29 ibid.,
### Table 7: Composition of the GMC 1858 - 1939

<table>
<thead>
<tr>
<th>Bodies represented on the GMC Added after 1858</th>
<th>Date of first election (and notes)</th>
<th>No date if 1858</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>England and Wales</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RCP of London</td>
<td>1860 (delayed first election)</td>
<td></td>
</tr>
<tr>
<td>RCS of England</td>
<td>1860 (delayed first election)</td>
<td></td>
</tr>
<tr>
<td>Apothecaries Society of London</td>
<td></td>
<td></td>
</tr>
<tr>
<td>University of Oxford</td>
<td></td>
<td></td>
</tr>
<tr>
<td>University of Cambridge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>University of Durham</td>
<td></td>
<td></td>
</tr>
<tr>
<td>University of London</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Victoria University (Manchester)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>University of Birmingham</strong></td>
<td>1900</td>
<td></td>
</tr>
<tr>
<td><strong>University of Liverpool</strong></td>
<td>1904</td>
<td></td>
</tr>
<tr>
<td><strong>University of Leeds</strong></td>
<td>1904</td>
<td></td>
</tr>
<tr>
<td><strong>University of Sheffield</strong></td>
<td>1904</td>
<td></td>
</tr>
<tr>
<td><strong>University of Bristol</strong></td>
<td>1910</td>
<td></td>
</tr>
<tr>
<td><strong>University of Wales</strong></td>
<td>1912</td>
<td></td>
</tr>
<tr>
<td><strong>Scotland</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RCP of Edinburgh</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RCS of Edinburgh</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Royal Faculty of Physicians and Surgeons of Glasgow</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Universities of Edinburgh and Aberdeen</td>
<td>(separate representation after 1886)</td>
<td></td>
</tr>
<tr>
<td>Universities of Glasgow and St Andrews</td>
<td>(separate representation after 1886)</td>
<td></td>
</tr>
<tr>
<td><strong>Ireland</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RCP of Ireland</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RCS in Ireland</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apothecaries Hall of Ireland</td>
<td></td>
<td></td>
</tr>
<tr>
<td>University of Dublin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Queen’s University (late of Belfast)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Royal (later National) University of Ireland</strong></td>
<td>1883</td>
<td></td>
</tr>
<tr>
<td><strong>Public and Profession</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Privy Council (initially 4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registered Profession (initially 5, increased to 7)</td>
<td>1887</td>
<td></td>
</tr>
</tbody>
</table>

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30 GMC, *Minutes*, 1939, LXXVI: pp. ix - xv. The listing order here is taken directly from the *Minutes* and appears to reflect a ranking of organisations and representation. The public and profession come last, the public saved only by their representatives being appointed by proxy by the Monarch!
The development of the GMC as a disciplinary body

Smith quotes W K Pyke Lees, writing in 1957, as stating that the disciplinary work of the Council was created by “half a dozen inconspicuous lines” in the Medical Act 1858. Section 29 read,

> If any registered medical practitioner shall be convicted in England or Ireland of any felony or misdemeanor, or in Scotland of any crime or offence, or shall after due inquiry be judged by the General Council to have been guilty of infamous conduct in a professional respect, the General Council may, if they see fit, direct the registrar to erase the name of such medical practitioner from the Register.

Smith has also described the British profession in the 1850s as having “no such formal guidelines of good professional conduct ... they developed out of the decisions handed down by the Council in disciplinary cases decided over the years”. This is only technically true. The profession did not exist as such anyway, but the RCP and bodies like it did, and as I have shown there were ‘formal guidelines’ in the RCP’s bye-laws. What is more, its general disciplinary bye-law was remarkably similar to the GMC’s, and may well have been its model. It is also important that the Council’s first registrar, Dr Francis Hawkins, who held office for 18 years, was a highly conservative Registrar and Elect of the RCP.

However, the College had a secure legal base in its Charter and Bye-laws, whilst the GMC had to spend a number of years developing and refining its disciplinary machinery, often in response to events, particularly legal challenges. When first requested to institute “due enquiry” into the case of Dr R Organ in 1860, there was no mechanism in place to deal with the problem. The Council’s lawyers opted for a quasi-judicial approach. The practitioner successfully appealed against their decision to erase, on the grounds that he had not been heard. A number of important appeals in the late nineteenth century helped define the legal power of the Council to hold these hearings.

In 1863 the Court of Appeal unanimously upheld a decision to erase a practitioner who had published a work on the dangers of masturbation, stating that the Court had no power to intervene after “due enquiry”.

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claim that the publication of the Council’s decision was libellous. In the famous case of the medical naturopath Thomas Allinson in 1894, the Appeal judges gave a definition of the Council’s power to define the exact nature of “infamous conduct in a professional respect”.

If a medical man in the pursuit of his profession has done something with regard to it which will be reasonably regarded as disgraceful or dishonourable by his professional brethren of good repute and competency, then it is open to the GMC to say that he has been guilty of infamous conduct in a professional respect.

Harper, the Council’s Solicitor, reviewing these cases in 1912 found none that added new precedents to the Council’s scope and power after 1897. Thus by the turn of the century the Council had a free hand to erase as it saw fit. Such power was bound to be attacked, not least on the grounds that the procedures underpinning it were inadequate. Indeed Smith’s legal critique of the Council is simply one of a long pedigree. Before turning to these critiques I shall outline the disciplinary procedure as it stood in 1926.

On receiving a complaint or information about a doctor’s conduct, the Council used a Committee of five members, plus their Judicial Assessor and Solicitor to decide if there was sufficient evidence to warrant an inquiry, a warning letter, or no action at all. Accusations of “infamous conduct” needed to be formulated in writing and accompanied by a statutory declaration of the alleged facts. The GMC described their hearings as “inquiries”, and these were heard by the full Council, those present numbering anywhere between 20 and 40 members. Both the complainant and the defendant could be present and represented by Counsel or a Solicitor. The hearings were public, and witnesses were examined and cross-examined. Members of the Council (the “jury”) could question the witness through the Chair, whilst any legal points or conflicts of evidence would be assessed and presented to the Council by the Judicial Assessor “as a judge would for a Jury”. Having heard the evidence and any comments of the defendant, the Chairman would request that “Strangers withdraw”, and the Council would deliberate in camera.

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39 GMC, The General Medical Council, Memorandum as to the constitution, functions and procedure, London, GMC, n.d.
71926, also published in Lancet, 1926, i: 6.2.1926. This was produced in response to a controversy in the Press over a practitioner erased in 1911 described in chapter 9. It is useful because the Registrar, Norman King, felt compelled to describe the disciplinary hearings of the Council in some detail.
Despite having only one charge and one sentence to hand down, the Council managed to introduce some flexibility into the system.\textsuperscript{40} They could of course decide not to investigate, and simply to warn the practitioner. Having investigated they could either find the case not proved, suspend a sentence on condition of improvement, or change in the practitioner’s conduct, admonish the practitioner, or direct, immediate and permanent erasure from the Register.\textsuperscript{41} It was also possible for a case for re-registration to be presented to the Council, but this process was often complicated by the fact that the Royal Colleges would strip the practitioner of his diplomas when the practitioner was erased. Thus the practitioner could find himself without registrable qualifications, and doctors who had no University degrees were at a distinct disadvantage.

**Contemporary criticisms of the GMC**

Attacks on the GMC during the early 1920s focused on its role as guardian of medical orthodoxy and defender of medical pecuniary interests, (precisely the outcomes for which many doctors had campaigned in the 1890s), but more detailed legal critiques are of more interest to us here. Leonard Minty, a barrister who had represented a Col. Kynaston before the Council in the 1920s, wrote a book, which whilst it attacked quackery in all forms (osteopathy, cheap opticians, abortionists etc) also attacked the GMC on a number of counts.

The GMC, Minty said, had been given no true disciplinary powers, and in his opinion, “the words ‘infamous conduct’ were no doubt meant by the legislators of 1858 to mean high moral turpitude, such as seducing a married woman who was at the time the practitioner’s patient.”\textsuperscript{42} Furthermore there was, unlike the procedures under which lawyers were debarred, no mechanism for restoring names or hearing appeals. Instead the Council “have taken to themselves a semblance of the disciplinary authority by construing the words, ‘infamous conduct in a professional respect’ to mean anything of which they disapprove”. The worst problem with this was that the nature of “infamousness” constantly shifted. Whilst Col. Kynaston and Dr Allison were struck off for advertising a member of the Council had publicly endorsed Marie Stopes’ “exorbitant” works. What was worse the Council gave no advanced warning of whether they might find a particular activity infamous until they had heard a case.\textsuperscript{43}

\textsuperscript{40} Harper, *Decisions under the Medical Acts*, 1912, p. xx.

\textsuperscript{41} GMC, *Memorandum*, 1926, pp. 9 - 12


\textsuperscript{43} *ibid.*, pp. 9 - 13.
Minty also felt there were serious problems with the inquiries as legal procedures. There was no way of knowing in advance what evidence would be brought by the other side, hearsay was admissible as evidence, and the Council had no power to compel witnesses. Referring to the 1894 Appeal Court definition of “infamous conduct in a professional respect” he noted that the “jury” were “men whose social and professional status is vastly superior to [the defendant’s] own”. Far from being “his professional brethren of good repute and competency” they were “men of quite extraordinary repute and competency”. These were all reasonable points, and repeated in another legal analysis of the Council in the 1940s. The Council was also described by A J Cronin at the climax of his polemical medical novel *The Citadel*, as “a second-hand law court”. Cronin’s narrative also made the point that the mechanism by which doctors came before the Council, that of complaint, was open to bias; his hero was simply shopped by a group of disgruntled and threatened colleagues. Harry Roberts, another popular medical author, writing in the same year (1936) noted that “opportunities for blackmailing and vindictive charges are obviously many”. This is perhaps borne out by the number of complaints of adultery brought by the spouses of patients (see below).

The Warning Notices

One of Minty’s criticisms - that doctors were not forewarned as to whether or not some activities were “infamous” or not - was shared by the BMA. The Association was instrumental in requesting that the GMC produce statements to the effect that advertising was an activity that could lead to erasure. (See chapter 9.) By the 1920s the Council was producing a leaflet usually called “The Warning Notices”, but these had evolved out of other less systematic notices published from the 1890s onwards. (Despite the fact that Smith has published two articles which deal with the Notices, the story of exactly how and where the notice evolved and what it contained remains incomplete, a state of affairs I have not been able to remedy using the available sources.) By the 1920s the

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44 *ibid.*, pp. 15 - 21.
47 Harry Roberts (1871 - 1946) is another fascinating figure to whom there is little space to devote here. Born in Somerset, educated at Bristol University and St Mary’s Paddington, he found Cornish general practice too stultifying and moved to practice in the East End of London. His obituarist commented that he managed to “combine the life of a busy east End practitioner with authorship of high quality, the pursuit of many intellectual tastes and the cultivation of his garden and orchard.” He was evidently no respecter of persons, whilst being well-connected, and published widely on medical and social matters.
Notices were being widely reproduced, and whilst I shall discuss their content in more detail in the next chapter, I shall sketch what is known of their evolution here.

It is consistently evident that the Council was keen not to define professional misconduct in too much detail - as Squire Sprigge said the Notice could not be "prophetic" of the novel offences of "an ingenious bad man" - it preferred to judge each case on its merits. This said, a number of offences were felt by the Council to be so frequently committed that it was necessary to publish a statement on them. Yet this can have been of little comfort to practitioner called up before the GMC. Smith give two examples, one from 1865, in which a Dr Theobald was charged with publishing and circulating *Electro-Homeopathic Medicine*. In appealing he said, "I am left entirely in the dark as to what kind of objections are found by the GMC in these passages, and how I am to answer them." As late as 1983 a doctor was disciplined for the use of a controlled drug having actually sought the Council's guidance in advance.

The first such Notice was published in 1886 in response to a growing number of cases of "covering", but was initially just recorded in the minutes. It was resolved,

> That the Council record on its Minutes, for the information of those whom it may concern, that charges of gross misconduct in the employment of unqualified assistants and charges of dishonest collusion with unqualified practitioners in respect of the signing of medical certificates required for the purposes of any law or lawful contract, are if brought before the council regarded by the Council as charges of infamous conduct in a professional respect.

Cases continued to come forward, and the Council realised that few doctors had read their *Minutes*. It was decided to publish their resolution for two weeks running in a number of medical journals. A similar procedure seems to have been adopted with other resolutions relating to "covering", "canvassing and advertising" as they were passed. For instance an issue of the *BMJ* from 1896

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49 For instance they appeared in the BMA's *Handbooks*, in the Sprigge's *Conduct of medical practice* (see below) and were included in copies of the Register and were certainly available as lose offprints - several exist in the BMA material in the CMAC collection.


51 GMC, *Minutes*, 1914, LI: 54 - 57, (1.6.1914)

52 GMC, *Minutes*, 1865, XXXII: p194, (22.7.1865)


54 GMC, *Minutes*, 1883, XX: p. 91, (20.4.1883)
which retains its advertisement section carries “Important Notices” relating to the need to register, and to the questions of covering unqualified persons or employing them as assistants.\(^{55}\)

Smith states that “from the turn of the century a formal ‘Warning Notice’ was issued to all newly qualified medical practitioners” and that the notices were “revised and consolidated” in 1914\(^{56}\) by which time they contained notices included at the instigation of the BMA, (see chapter 9). This consolidated Notice contained sections on certification, unqualified assistants, sale of poisons, association with unqualified persons, advertising and canvassing.\(^{57}\) Between 1920 and 1958 the Warning Notice was printed in the front of the bound volumes of the \textit{Medical Register}. Thus, the GMC was not acting as a parliament making prohibitive laws - it was issuing “a condensed statement of the successive judgements of the court”.\(^{58}\)

\textbf{The GMC and the BMA}

It is quite apparent in many of the archive materials that there was a confusion in the mind of the public and Press on the distinction between the GMC and the BMA,\(^{59}\) and that many involved in each organisation found this annoying.\(^{60}\) However, as I hope to show, the confusion was not as unreasonable as might be supposed. Both organisations were seen as powerful organisations acting on behalf of the medical profession, and there were many important areas in which the two organisations co-operated.

The relationship between the BMA and the GMC was never straightforward and in the following two sections I shall detail two conflicting aspects of what might be called ‘the BMA’s GMC policy’. Under what I have termed their ‘Direct Representatives Scheme’, the selection and election of the Direct Representatives for England and Wales, (introduced by the 1886 Medical Acts, and for which the BMA had campaigned,) were effectively rigged so that the positions were always awarded to leading BMA figures. On the other hand the question of the propriety of the Association’s acting as a complainant (that is as a presenter of cases) before the GMC was never

\(^{55}\) \textit{Br. med. J.} 1896, II: advertising page 3 (15.8.1896). Held by the BMAA.


\(^{57}\) GMC, \textit{Minutes}, 1914, LI: 54 - 57, (1.6.1914).


resolved, and the Association appears to have settled into a role as ‘covert complainant’. Both these areas, and activities detailed later in this thesis, show that the Association, whilst always keen to distinguish itself from the GMC, was also very keen to influence it. They had after all played a key part in setting up the GMC in the first place.

The BMA’s Direct Representative scheme

The scheme was instigated in 1903, first used in 1906 and was still in use in 1950, essentially unchanged. Margaret Stacey noted that in the early 1970s (when far more members were directly elected,) the BMA was still supporting candidates, along with organisations like the British Hospital Doctors Federation and the Medical Practitioners Union.

A resolution of the ARM of 1903 asked the Medico-political Committee to consider the advisability of running a candidate under the auspices of the BMA. Candidates were to be selected from a list of Division nominees by a special meeting of divisional representatives at the time of the ARM. It had been originally suggested that these candidates should sign a declaration that they would not stand against a BMA candidate if they were not chosen, and that whilst on the GMC they would “give effect to the wishes and opinions of the BMA”. These stipulations were felt to be too restrictive and were dropped. For the November 1906 election to the GMC 13 candidates were considered for the 2 places as Direct Representative for England and Wales, and the ARM delegates selected Thomas Jenner Verrall, and Henry Langley Brown to stand. At the election they the gained far more votes than the candidates who were not supported by the BMA, and thereafter no direct representative for England and Wales was elected to the GMC without the ‘BMA ticket’.

Meanwhile the GMC was approached and asked to increase the number of Direct Representatives on the grounds that the number of registered medical practitioners had increased since 1886. The BMA was probably involved in this approach in some way; the MPC was certainly unhappy that although the GMC voted to increase the number by one, some BMA members on the Council voted

63 ARM, 1903.
64 ARM, 1906.
65 Sir Thomas Jenner Verrall, (1852 - 1929) was a son of a prominent JP and solicitor in Brighton, educated at Marlborough College and St Bartholomew’s Hospital and qualified MRCS LRCP in 1876. He became a GP and surgery in Brighton, but was described as “too literary in his tastes and his habit of mind”. He was knighted for his work on the Central Medical War Committee, having served on the BMA Council from 1893 onwards, as well as the reforming 1900 constitution committee. He was direct representative on the GMC from 1912. *Br. med. J.*, 1929, ii: 695 - 7.
against or abstained. The MPC felt strongly enough to circularise Divisions in which these members lived asking them to “make representations” to these GMC members.

For the 1911 election there were three representatives to be elected, and the MPC decided to adopt the previous scheme. Notwithstanding the overwhelming victory at the last election, additional measures were introduced. An address signed by the three candidates was published by the *BMJ*, and once the voting papers had been issued it was decided to ask all BMA members to support these candidates. Once again the BMA candidates won easily. In 1919, although the scheme was working very well, further alterations were recommended. It was felt necessary to make more effort to appeal to individual voter. A series of meetings was set up in all major cities, and in any Divisions that requested one, and postcards were sent to all members few days before the voting papers reminding them to support their candidates.

For the elections of 1925, and 1929, and a bye-election in 1926 the BMA continued to push for a good turnout and to put forward the only successful candidates. Typically BMA candidates polled 11,000 votes, whilst the other 2 candidates got 3,000 and 4,000 each and each campaign cost the Association around £250. The BMA Council still wished to pursue the goals established by the campaign for Medical Reform in the mid-nineteenth century (a predominantly elected GMC with total control of medical education, and a single portal of entry). However, they felt it was unwise to push for further Direct Representatives on the grounds that the GMC had had some bad press, and because such requests had only been acceded to with some difficulty in the past. It was also felt that the low turn out (“nearly half the profession are still not sufficiently interested to vote”) went against the Association’s argument.

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67 MPC, 7.4.1910.

68 Not all the places came up for election at once; members were elected for terms of 5 years, and deaths and retirements staggered the elections.

69 MPC, 4.1.1911.

70 Parliamentary s/c of MPC, 17.10.1911.

71 Parliamentary s/c of MPC, 1.12.1919.

72 MPC, 23.1.1924.

73 MPC, 24.5.1926.

74 See, ARM 1906.

75 Council, 3.12.1924.

76 MP and Parliamentary C, 4.3.1925.
In 1930 the MPC once again considered the question of increasing the direct representatives, after the Medical Women’s Federation had expressed the opinion that the time had come for a fifth such representative. A proposal written by the MPC with WMF approval was put to the GMC early in 1931, mentioning the “strong feeling” on the subject. Privy Council granted this additional representative in August 1931. Thus for the 1933 elections the BMA put forward 5 candidates in the customary fashion and with the usual success, one of those elected being Christine Murrell, President of the WMF and member of the CEC. Sadly she died a few months later in January 1934, and Guy Dain was selected and successfully elected to fill her place later that year.

It was after this election that the first clear voices were raised against the BMA’s scheme. In November 1934 the Council discussed a recent article from the *Lancet* which, whilst allowing that the candidates were good and useful members of the GMC, said that the method adopted by the BMA was not a free and unfettered vote of the profession. “The election of direct representatives does not really take place on the day fixed by the Council but at the moment when a notice appears in the Supplement of the BMJ indicating the result of the selection by the constituencies of the Representative Body” they said. As far as Dain’s election was concerned, “no private candidate could possibly have a chance of success against such a nominee.” There was some discontent within the BMA too, the Kensington Division wrote to the MPC about the appeal in BMJ supplement to support the BMA candidates for election saying “[its] character is undignified in the extreme and not worthy of a professional body of the standing and repute of the Association.”

Although in April 1935 Council decided approve the usual scheme, the wording of the circulars was changed so that they no longer said to be “on behalf of the Association”.

In all 20 members of the GMC were elected and served as Direct Representatives between 1887 when the first direct representatives sat on the GMC, and 1939. Of these 13 were elected under the BMA Direct Representatives scheme, and all were members of the BMA Council at the time. A number of other active BMA members served on the GMC including Victor Horsley, a Direct Representative, and others elected by the Universities, Colleges or the Corporations. It is worth

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77 MPC, 12.3.1930.
78 ARM, 1930.
79 See biography, p. 323.
81 MPC, 13.3.1935.
82 Council, 7.11.1934.
noting that at the time of his death Robert Bolam, a Direct Representative and later University of Durham member, was widely expected to be the Council’s next President.\textsuperscript{83}

\textit{Table 8: Prominent BMA members serving on the GMC up to 1939}\textsuperscript{84}

<table>
<thead>
<tr>
<th>Name</th>
<th>Dates on GMC</th>
<th>notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Representatives for England and Wales</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Victor Horsley</td>
<td>1887 - 1906</td>
<td>not a 'scheme' candidate</td>
</tr>
<tr>
<td>Leonard McManus</td>
<td>1907 - 1911 (died)</td>
<td></td>
</tr>
<tr>
<td>Henry Arthur Latimer</td>
<td>1907 - 1919 (died)</td>
<td></td>
</tr>
<tr>
<td>Henry Langley Brown</td>
<td>1906 - 1919</td>
<td></td>
</tr>
<tr>
<td>Thomas Jenner Verrall</td>
<td>1912 - 1929 (died)</td>
<td></td>
</tr>
<tr>
<td>Robert Bolam</td>
<td>1911 -</td>
<td>represented Durham University 1928 - 1939</td>
</tr>
<tr>
<td>James A Macdonald</td>
<td>1911 - 1928 (died)</td>
<td></td>
</tr>
<tr>
<td>Edward Beadon Turner</td>
<td>1911 - 1925</td>
<td></td>
</tr>
<tr>
<td>Henry Brackenbury</td>
<td>1925 -</td>
<td></td>
</tr>
<tr>
<td>Nathaniel Bishop Harman</td>
<td>1926 -</td>
<td>member CEC</td>
</tr>
<tr>
<td>John Wardle Bone</td>
<td>1928 - 1938</td>
<td></td>
</tr>
<tr>
<td>E Kaye le Fleming</td>
<td>1928 - 1938</td>
<td></td>
</tr>
<tr>
<td>Christine Murrell</td>
<td>1933 (died)</td>
<td>member CEC</td>
</tr>
<tr>
<td>Guy Dain</td>
<td>1934 -</td>
<td></td>
</tr>
<tr>
<td>Privy Council Appointees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Charles Hastings</td>
<td>1858 - 1863</td>
<td>founder of BMA</td>
</tr>
<tr>
<td>Robert Christison</td>
<td>1838 - 1873</td>
<td>member 2\textsuperscript{nd} failed Ethical Committee</td>
</tr>
<tr>
<td>John McVail</td>
<td>1912 - 1922</td>
<td>Member 1901 constitution committee</td>
</tr>
<tr>
<td>University Appointees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thomas Clifford Allbutt</td>
<td>1908 - 1918</td>
<td>(Cambridge) President BMA</td>
</tr>
<tr>
<td>Robert Bolam</td>
<td>1928 - 1938 (died)</td>
<td>(Durham)</td>
</tr>
<tr>
<td>Robert Saundby</td>
<td>1905 - 1917</td>
<td>(Birmingham) member and chair CEC</td>
</tr>
</tbody>
</table>

\textsuperscript{83} (Sir) Robert Alfred Bolam (c1871 - 1939) was the son of a Newcastle chemist, and worked in the city all his professional life. After qualifying, he worked in the Physiology Department at King’s College Hospital, with W D Halliburton, then as physiology demonstrator with Thomas Oliver in Newcastle. He became Physician and Pathologist to Royal Victoria Infirmary. He was Vice-chancellor of Durham University 1936 - 7. His BMA career began as a Division Representative in 1913, moving to the Council in 1915, becoming its Chairman in 1920 for 7 years. He was on the GMC between 1920 - 1939. He had evidently died suddenly. 

\textit{Br. med. J.}, 1939, i: 953, 1009.

\textsuperscript{84} A complete list of all members of the GMC up to 1939 is given in, GMC, Minutes, 1939, LXXVI: pp. ix - xv.
The BMA as complainant to the GMC

I have analysed the case-by-case index given by Smith in his thesis[^85] to give some general indication of how cases came before the GMC. The clearest trend was for the number of complaints coming from individual doctors or medical organisations to fall, and the number arising routinely out of court cases (shown in green) to rise. (See Figure 1) The index also reveals that of lay complainants by for the majority were the spouses of seduced patients. In the 1890s the MDU (brown) exceeded the Courts as a source of cases, but their activity declined thereafter. After a brief flurry of activity in the 1910s the BMA (red) once again became a very minor overt complainant. The reasons for this changing BMA profile are discussed below.

Figure 1: categories of complainants before the GMC (where stated)

Given that the Association expended so much time and effort making sure that some of its leading figures sat on the GMC, it is striking there was considerable confusion over the propriety of the BMA acting as a complainant. The question was whether the Council could be an impartial judge of a case in which some of its members were implicated by association. This problem had come to light in one of the cases already discussed, and the principle involved had in fact been decided in relation to the MDU.

As we have seen, medico-politically active doctors were often involved in more than one organisation. A number of members and Councillors of the MDU sat on the GMC, although I have not seen any evidence of deliberate attempts to place these people there. The MDU was also, as figure 1 shows, a major source of cases presented to the GMC in the 1890s and 1900s. In 1889 a Dr Leeson was erased from the Register after the MDU brought a case against him for “covering” a lay medical electrician. Leeson’s appeal rested on the ground that the GMC hearing had been biased by the fact that two members of the Council were subscribers to and guarantors of the MDU. (They were James Glover, elected as a Direct Representative in 1887, and Thomas Teale, a Privy Council nominee between 1858 and 1901.) The appeal judges were divided, 2 to 1, Edward Fry, believing that dual membership was a source of bias in the minority. The majority decided that “since the two were not actively and constructively accusers, the decision of the Council was valid”. However, they also “expressed the hope that in future members of the Council would cease to be subscribers to any society which brought cases before the Council”.

A subsequent decision, in Allinson’s case, was also favourable to medical politicians; the case having originally been brought by the MDU. In Allinson’s appeal the ‘bias’ argument was put forward again. The judge decided that the position of a person who might be a biased adjudicator “need not be such that he cannot be suspected [at all] ... but he must bear such a relation to the subject matter of adjudication that he cannot be reasonably suspected.” Despite this, the divided opinion in the Leeson case, along with the frequent failure of members of complainant organisations to resign their memberships on appointment to the GMC caused continuing ambiguity on this point.

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87 Harper, Decisions under the Medical Acts, 1912, p. xxii. [59 LJ (Ch.) 233]
88 ibid., pp. xxii and 153. [63 LJ (QB) 534]
For a time, in the 1910s and 1920s the BMA did act openly as a complainant before the GMC, but not without a considerable internal wrangle. In 1905 the Committee sought Council’s approval for the expenditure of up to £10 in preparation of cases to go before the GMC. The next year they proposed a clearer policy to the Council, in a motion stating that it was,

absolutely necessary in the interests of the medical profession that the Association should take up cases of a penal nature before the GMC as complainants [and] That in order to effect this, members of the said Council who are also members of the British Medical Association should at once on election, or immediately after election, cease to be members of the BMA during such time as their appointment lasts.\(^9\)

This motion was prompted by the case of man who had consistently canvassed for patients, but in which the committee had nearly failed to secure an erasure. The CEC had gathered evidence and placed it at the disposal of the GMC, believing the GMC would act. In the event the GMC requested either that the BMA appear as complainants or that they “get somebody else to”. At the last minute two local doctors were telegraphed and travelled up to London from South Wales to testify, and the doctor was struck off.\(^9\)

The Council postponed discussing the question in July, and thus the motion was put first before the ARM 1906 first, where it was passed. In October’s Council meeting no debate had occurred and the subcommittee’s instructions from the CEC to prepare cases for the GMC, if urgent, was simply noted. In January Langley Browne,\(^1\) who had just been elected to the GMC under the Direct Representatives scheme, wrote to the CEC stating that he felt the need to resign from the CEC. Following this a strongly worded condemnation “of the action the [CEC] had taken” had been put to Council.\(^2\) Despite the existence of a previous legal opinion to the effect that the Association could bring cases to the GMC unless stopped by the High Courts, the new chairman Edmund Owen (who was shortly to run foul of the CEC - see Chapter 6) sought a fresh opinion from a Mr Colquhoun Dill. Dill was of the opinion that the BMA could not “safely engage in ... proceedings” before the GMC, and was overstepping its Memorandum. Faced with this the Council voted simply to pass on

\(^9\) Council, 4.7.1906 in BMAA, B 54/2/15.
\(^1\) Langley Browne was, as Chair of Council 1905 - 1907, an ex-officio member of the CEC and had attended two meetings during 1906. This identification has been deduced from the description “late Chair of Council” given in summer 1907, and the fact that Langley Browne that he had recently been elected to the GMC.
\(^2\) Br. med. J., 1907, ii: supplement, 3.8.1907, p. 97. The motion is missing from the contemporaneous account of the meeting in the supplement, and from the minute books, and thus was almost certainly lost. Sadly this means we cannot learn who put the motion.
to the next business, apparently believing that the CEC did not have a mandate to act from the ARM.93

After a lengthy and ill-tempered debate, the 1907 ARM voted in support of Kinsey who moved that the CEC's action in bringing certain cases before the GMC in 1906 was justified and "should not be discontinued only on the ground of the position of members of the GMC". J Hamilton (member of Council for Glasgow and West Scotland) moved that the decision on 1906 should be rescinded. He disliked the shift from the "moral suasion" model of CEC work to "something stronger", and the fact that prominent members of the Association felt impelled to resign on election to the GMC, with the consequent loss of prestige for the BMA.94 Kinsey pointed out that the Council had postponed consideration of the 1906 motion to October "because it was so serious", and had then overlooked it. "Was it because it was so serious that it was forgotten in October?", he asked. The ARM backed Kinsey again, and Hamilton's motion lost by 1:98.

In the long term most BMA members elected to the GMC did not resign from the Association, and the question was never clearly resolved. A variety of different strategies were carried out at different times, the most common being for the President of the GMC to request members of complainant organisations to withdraw for the relevant cases. For example in the case of the Sandow Curative Institute doctors, brought by the BMA in 1911, four Association members including Robert Saundby were requested to withdraw.95 A Lancet editorial of 1934 commented that "inconvenience continues to arise" out of this practice. The article referred to one case in which 7 out of 37 (MDU members) withdrew and another where 12 out of 28 (BMA members) withdrew and commented that this might actually amount to injustice. The Lancet argued that the opinion of Edward Fry on the Leeson case "may have been given ... an almost extravagant respect" over the years, (he was after all in a minority,) that such withdrawal was overscrupulous, and that these "quasi-judges" should be given the benefit of the doubt.96 Two BMA men, Donald

93 ibid., p. 98.
94 ibid., p. 99.
95 This was a very interesting case, involving charges of "covering" and "advertising". Hence it has not been included in the chapters on either subject. It was brought against 3 doctors who were checking the fitness of "pupils" of Eugen Sandow, a retired circus strongman, who had set up an institute for remedial exercise. One of these, Col. Kynaston went on to give further trouble for the GMC in the 1920s. See, Minty, Medical Quackery, 1932, pp. 14 - 15, and GMC, Minutes, 1911, XLVIII: pp. 62 - 65, 70 - 72.
96 Lancet, 1934, i: 41 - 2
MacAlister and Robert Bolam, who rose to high positions in the GMC found that as they reached higher office they had to resign from the Association.97

There is however consistent evidence for quite another strategy by the BMA, that of “covert complaint”. For example in 1903 in a case involving persistent advertising, the Medical Secretary of the BMA had made a statutory declaration. The GMC had then informed the doctors licensing body, the result being that the advertisements were withdrawn, and the practitioner had promised not to re-offend. A number of cases were reported to the RCP (Edinburgh) which resulted in cases before the GMC.98 Sometimes the Association persuaded individuals to complain. Dr R V Storer, was a doctor specialising in the treatment of venereal disease, and who appears to have been regarded with distaste from the outset. Marylebone Division had requested that the BMJ drop the advertising they were carrying for Storer’s “Cavendish Clinic” in early 1934,99 and he subsequently turned to advertising in the lay press. In November of that year, Anderson wrote to Michael Heseltine, Registrar of the GMC, “may I draw your attention to the enclosed advertisement from this morning’s Times. You will have no difficulty, I am sure in associating the advertisement with Dr R V Storer ... You will appreciate that I should not want to appear as complainant in the case; I simply bring the facts to your notice”.100

The next letter was from a Dr Guy Bousfield of the Camberwell Research Laboratories (which we can assume was involved in the same line of work as Storer) who wrote, “I return the cutting from the Daily Express which Dr Hill so kindly lent me. I enclose a formal protest on the subject for your approval. ... I would be obliged if you could forward it to the GMC”,101 which Anderson did immediately.102 In May 1935 Dr Storer was erased from the Register for advertising. The report of his GMC hearing stated that there was “no complainant”.103

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97 Br. med. J., 1939, i: 953. Bolam was widely tipped to be the next President of the GMC when he died, and MacAlister served as President 1904 - 1931.

98 Ethical Committee, Annual Report ... 1903 - 1904. Appendix, pp. 139 - 142, in BMA A A/1/1/2.

99 letter, Ferris Scott, to Macpherson, 6.2.1934, in, CMAC SA BMA D159.

100 letter, Anderson, to Heseltine, 16.11.1934, in ibid.


102 Letter, Anderson to Heseltine 23.11.1934, in ibid.


82
The Medical Defence Union

This account of the MDU has been based largely on the short book produced by the Union’s Secretary, Robert Forbes, on its 60th anniversary. I have not been able to locate any other published works on or by the MDU, and Forbes, whilst being a “living link” to the world of early twentieth century medical ethics, achieved a reasonably balanced, dispassionate and informative account. The MDU, which still provides indemnity insurance for around half of British medical practitioners, was set up as a company limited by guarantee in 1885. Its objects were:

(i) To support and protect the character and interests of medical practitioners practising in the United Kingdom
(ii) To promote honourable practice and to suppress or prosecute unauthorised practitioners
(iii) To advise and defend or assist in defending members of The Union in cases where proceedings involving questions of professional principle or otherwise are brought against them
(iv) To consider, originate, promote and support (so far as it is legal) legislative measures likely to benefit the medical profession and to oppose all measures calculated to injure it; and for the purposes of aforesaid to petition Parliament and take such other steps and proceedings as may be deemed expedient

As can be seen, these aims are far broader than the current role of the Union, and represent an attempt to overcome the lack of effective medico-political structures perceived by many doctors in the late nineteenth century. There were already two small national organisations, the Medical Defence Association, and the Medical Alliance Association, but as these collapsed their leaders came to be members of the Council of the MDU. The early history of the MDU was chequered, and at one point it was only saved by the personal financial intervention of the President Lawson Tait. Tait had been instrumental in setting up the powerful Birmingham and Midlands Branch. These and other local branches were seen as ways of providing locally based support and important foci for recruiting activity.

Between 1888 and 1894 the MDU was effectively based in Birmingham and early on it decided that it could not deal with inter-practitioner law suits. Indeed when it first had to deal with such matters, the Council found that “the relationship between those concerned was so complex and their statements so opposed, that it was impossible ... to effect any satisfactory solution upon the matter.

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104 Forbes, Robert, *Sixty Years of Medical Defence*, London, Medical Defence Union Ltd, 1948. Forbes' biography appears on p. 332. He went on to serve on the GMC and on the CEC becoming its chairman in the 1950s. This work was evidently based on a quite detailed knowledge of materials held by the Union as well as some personal knowledge and access to the memories of others, and was carried out with some skill. Whilst it is evidently an “insider” account it is dispassionate in tone and somewhat revealing in its historiographical innocence.

105 Tait is now remembered as the first person to operate on a ruptured ectopic pregnancy.
This case serves to illustrate the desirability of forming local branches for the consideration of subjects coming under this head."\(^{106}\)

The MDU brought the case of a doctor who was working with “VD quacks” to the GMC in 1888; the first case of what became known as “covering”. The Union Council “believed that the elimination of unqualified practice and the disclosure of “covering” were necessary for the effective protection of orthodox medical practice, but some apprehension was expressed ... lest the limited funds ... should be diverted from the primary purpose of defending its individual members”. However as the Union grew it was always able to find funds to support this purpose.\(^{107}\)

The Council of the MDU was its executive, and deliberated on the cases with which the Union dealt at its quarterly meetings, and its officers were responsible for carrying matters forward between meetings. Between 1888 and 1892 the annual meeting of the Union elected all these personnel, but by 1892 this structure, along with expensive local branches was felt to be inefficient. The branches were wound up and the Councillors were elected to serve for four years instead of one.\(^{108}\)

From 1894 the practice of using the full Council to consider every item of business was streamlined by forming a smaller Executive Committee, which was reformed as the Council Committee in 1932. These meetings were important - the Union could choose not to defend the doctor if the case was not felt to be worthy of their support.\(^{109}\) They could also reject candidates for membership but only for “grave cause and strong reasons”. There was also by this time an “emergency committee” of London members who could meet to discuss urgent matters. As was the case with the CEC, the MDU Council relied on the accumulated experience of past decisions to an increasing degree. As Forbes said, “Today the Council has behind it a large store of accumulated experience and can offer advice or take up a case in accordance with established precedent. In 1888 every case was a new problem”.\(^{110}\) From 1908 the Union provided indemnity cover for doctors, moving it towards the modern role of a provider of insurance against medico-legal risk and an advisor on medico-legal difficulties. This had always been a role, but earlier in its history the emphasis had been on


\(^{107}\) ibid., p. 16.

\(^{108}\) Hugh Woods, an MDU Councillor felt strongly enough about the constitutional changes to set up the London and Counties Medical Protection Society in 1892, which continues to this day as the MPS.

\(^{109}\) ibid., p. 37.

\(^{110}\) ibid., p. 15.
defending doctors against what were assumed to be false accusations of wrong-doing, and the competition of unqualified healers.

The MDU and the GMC

Whilst the Union had dedicated itself to the suppression of unqualified practice, the GMC was a statutory body with no jurisdiction over the unqualified practitioners whatsoever. The Union Council evidently had little patience with such legislative niceties. According to Forbes: “The Council intruded energetically on what it conceived to be the complacency and inactivity of the GMC in relation to unqualified practice and ‘covering’. The more experience the Union gained, the more dissatisfied it became with the extremely cumbersome and faulty methods of procedure adopted by the GMC”.

They brought pressure to bear on the GMC in a number of ways. The first of these was by presenting cases to them, usually of “covering”, false claims of registration, and fraudulent qualifications. The Union also brought court cases against unqualified practitioners under the Medical Acts. In the years 1898 and 1905 the Union brought cases against 23 and 19 unqualified practitioners respectively. They also appear to have made direct approaches to the GMC (although Forbes gives no details of how this was carried out). As Green has noted, the MDU was very important in shifting the GMC into a position antagonistic to contract practice arrangements. Forbes described this work as being “in connection with its object of promoting honourable practice and maintaining a high standard of “ethical” conduct among the profession” and describes how Leslie Phillips, the Secretary, had prepared a memorandum for the GMC in 1892. As we have seen the GMC’s response to this approach was not that desired by Phillips.

The Annual Report of 1895 was highly critical of the GMC, but claimed some success in changing its stance, stating “There is no doubt but that the present conduct of the business of the Medical Council is wholly antagonistic to the best interests of the profession ... It has cost the Union several years’ work to make the Medical Council realise its duties as a prosecutor under the Medical Acts.” The Union pressed for reform of the GMC consistently up until the 1950 Medical Act.

111 Forbes, Sixty years of medical defence, p. 18.
112 Green, Working class patients, pp 29 - 48.
113 GMC, Minutes, 1893, XXIV: Appendix XII.
The MDU and the BMA

It is worth noting the similarity in the overall aims of the MDU and the reforming faction of the BMA. The BMA frequently debated proposals to provide indemnity cover either in competition with, or instead of, the MDU and MPS, but essentially the organisations became steadily more differentiated, the BMA remaining a broad-based organisation.

In fact there were very important overlaps between the BMA and the MDU in other ways. In 1903 MDU’s membership was a two fifths that of the BMA’s but all but one of the MDU Councillors were members of the Association. The experience that William Hempson had gained in working for the MDU since 1894 lead to his appointment in 1905 as the Association’s Solicitor too. (Hempsons’ are still the BMA’s solicitors). There was significant cross membership of the MDU and the CEC. The most important links were the three men who served as Secretaries to the MDU, Bateman, Neal and Forbes. Bateman’s flair at tracking down quacks and their allies, and prosecuting their cases before the GMC or the Courts was one of the MDU’s most important assets in the late nineteenth and early twentieth centuries. His successors James Neal and Robert Forbes both served first as Deputy Medical Secretaries to the BMA, in which role they were secretaries to the CEC, All three men served on the CEC and its sub-committee for the entire period they were in office as Secretary of the MDU. It is hard to imagine that this did anything other than harmonise the approaches of each body to issues of professional conduct. Two CEC chairmen were also MDU councillors, Saundby, whose initial exposure to medical ethics was as Treasurer to the Birmingham and Midland Branch of the MDU and councillor to the Union, and Arnold Lyndon. In all 4 out of 16 of the MDU’s Presidents in its first sixty years served on the CEC.

The MDU and the BMA were both expressly dedicated to the promotion or defence of professional honour. Both used the idea of local branches, and when the MDU dropped them the idea was considered important enough in principle to justify the setting up a rival defence organisation. Both organisations “elected” their members, and both employed regularly meeting groups of approximately the same size to meet at monthly intervals to consider cases and adjudicate on conduct. Their memberships overlapped, particularly amongst those actively involved in medical ethics, and the CEC seems almost to have served as a training organisation for MDU Secretaries.

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115 Annual Meeting, 1886, ARM 1903, 1921 and 1925.
116 See biography, p. 320.
Table 9: officers and long-serving Council members of the MDU with connections with the BMA and the CEC

<table>
<thead>
<tr>
<th>Name</th>
<th>MDU office(s)</th>
<th>CEC</th>
<th>BMA</th>
<th>GMC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Robert Saundby</td>
<td>Treasurer, Midland Branch, 1886</td>
<td>Chairman</td>
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<tr>
<td></td>
<td>Council, 1887 - 1900</td>
<td>1902 - 05</td>
<td>Council GPEC</td>
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<tr>
<td>Victor Horsley</td>
<td>President, 1893 - 97</td>
<td>Council</td>
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<td></td>
</tr>
<tr>
<td>M A Messiter</td>
<td>President, 1901 - 05</td>
<td>1906 - 07</td>
<td>GPEC</td>
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</tr>
<tr>
<td></td>
<td>Council 1888 - 1921</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>W A Elliston</td>
<td>President, 1905 - 07</td>
<td>1902 - 05</td>
<td>GPEC</td>
<td></td>
</tr>
<tr>
<td>Charles Ballance</td>
<td>President, 1920 - 23</td>
<td>1903 - 06,</td>
<td>Council Chair</td>
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<td>1902 - 10</td>
<td>RM</td>
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<td>A G Bateman</td>
<td>Secretary, 1888 - 1919</td>
<td>1902 - 19</td>
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<td>James Neal</td>
<td>Secretary, 1919 - 35</td>
<td>1910 - 12 &amp;</td>
<td>Deputy Medical</td>
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<td></td>
<td></td>
<td>1919 - 35</td>
<td>Secretary</td>
<td></td>
</tr>
<tr>
<td>Robert Forbes</td>
<td>Secretary, 1935 - 1848 +</td>
<td>1935 - 48 +</td>
<td>Deputy Medical</td>
<td>yes</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Secretary</td>
<td></td>
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<tr>
<td>C H Milburn</td>
<td>Council 1897 - 1922</td>
<td>1909 - 19 &amp;</td>
<td></td>
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<td>1927 - 28</td>
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<tr>
<td>Arnold Lyndon</td>
<td>Council, 1922 - 46</td>
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<td>Chairman</td>
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<td></td>
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<td>1926 - 33</td>
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<tr>
<td>Peter Macdonald</td>
<td>Council, 1926 - 1948 +</td>
<td>1923 - 29</td>
<td>Council Chair</td>
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Discussion

A number of important points come out of this set of inter-linked accounts. Firstly, the original form of medical organisation, the College, was copied in detail from the medical colleges of the Italian city states, but was also more generally based on the long history of occupational associations in the form of guilds. The Royal Colleges stressed two attributes in their members; firstly colleagues had to be of a particular grade of education and qualification, and secondly continued membership was conditional on maintaining a certain standard of conduct towards fellow members, and towards those outside the college. The medical associations formed in the early nineteenth century, of which the BMA was the prime survivor, inherited this sense of membership based on qualification and conduct, albeit in the context of a more widely defined membership. This pattern was, within the limitations of the statutory machinery set up by the 1858 Act, reflected again in the GMC’s role as regulator of both medical educational and medical discipline, although it took a long time for this to develop fully. Similar ideas were reflected even in the MDU; its members were “elected” and the Union initially concerned itself with issues of ethical conduct generally, and relationships with those outside the profession.

Forbes, Robert, Sixty Years of Medical Defence, 1948, pp 88 - 89.
In defining patterns of acceptable and unacceptable conduct all these organisations differed in their approach to codification, but were in some respects remarkably similar in the fundamental form of their disciplinary proceedings. The RCP had clearly set out written rules graded according to rank within the organisation, which were all initially framed as “secrets” of the College. The BMA and GMC developed a much more openly casuistic approach. The BMA resisted systematic codification until the 1930s, and the GMC published very limited guidance to doctors in the Warning Notices. All, however relied on a “hearing” of a group of putative peers, and all used expulsion as their ultimate sanction. Again, there was a wide range of “equality” between the judges and the judged in these organisations. In the case of the RCP, a small group of very senior doctors could sit on the case of a GP, whilst the BMA’s CEC was a tribunal formed of a more or less democratically chosen set of middle-ranking practitioners.

Thus despite the similarities and many connections, the newer ‘democratic’ medical organisations were quite different in disciplinary style, and the extent to which they were politicised. The GMC was in many senses caught between these two poles in something of a statutory bind. It consisted largely of elite practitioners, and yet it was charged with the definition of the whole profession. It reflected the fundamental features of ‘medical association’, but also reflected the tensions between different parts of the profession.

The BMA’s attitude toward the GMC was a means that varied according to the ends in mind. The Association would at one time suggest the Council act in a particular way using all the influence it could muster, and then present these edicts as independent Statutory statements which they were bound to follow. This could be seen as part of a wider web of connection and influence running between different medical organisations - particularly those set up in the nineteenth century.
Chapter 5

The CEC in context: the contemporary literature

Introduction

In this chapter I shall examine the early twentieth century British literature on medical ethics. This literature was remarkably small - only three books on the subject were published in Britain between 1890 and 1939 - but it shaded into a larger penumbra of works and materials on medico-legal problems, medical jurisprudence and an advice literature on how to conduct medical practice. I have examined representative samples of these types of works, and describe the relationship between them and the medical ethics literature.

The bibliography for this thesis was generated not only by the traditional methods of footnote-checking and shelf-browsing, but also by a comprehensive search on the British Library's on-line catalogue. The words and phrases “ethics”, “medical ethics”, “conduct”, and “professional conduct” were used as title-phrase and subject searches. Over 1,600 titles were retrieved using these searches. Almost all were either not relevant, or were obviously American publications, and of the remainder the vast majority fell outside the period of this study.¹

I shall not describe these works in great detail here, since detailed consideration of certain points will come out in the discussion in the second section of the thesis. I shall concentrate on whom they were written by (pointing out any links with the BMA), and why, how they defined and framed medical ethics, and lastly what they included and what they left out of their discussion. This exegesis also sets out much of the core character and content of early twentieth century medical ethics.

¹ Sadly one work, Norman Barnesby's enticingly titled Medical Chaos and Crime, (1910) is missing both from the libraries that list it (British Library and Wellcome Institute).
Three “greats”

Jukes de Styrap, A Code of Medical Ethics
1878 - 1895 (4 editions)

Jukes de Styrap (1815 - 1899), probably christened Jukes Stirrop, attended Shrewsbury School 1826 - 9, and was privately educated thereafter. He attended Kings College London and qualified MRCS LSA in 1839, and, after spending a number of years in Ireland, also qualified as LRCP(Ireland) in 1850. He then set up in practice in Shrewsbury and helped found the Salopian Medico-Ethical Society, merged later with the Shropshire Branch of the BMA. In 1859 he became a Physician to Salop Infirmary. After a “severe illness” in 1864 he was “practically confined to his house on College Hill, Shrewsbury”.

De Styrap claimed “upwards of twenty years official experience in ethical disputes” from his involvement in local medico-political work. The Code evolved over time; starting as a relatively slim volume, based on an amalgam of the codes of “various Medico-ethical societies” and the AMA code, originally undertaken for his local medical society. The influence, and at times even the phraseology of Percival are evident in de Styrap’s work. He pointed out that the frequent requests for guidance, the interest of Charles Hastings in a BMA sponsored code, and the existence of local codes all indicated the need to formally record the lex non scripta of medical ethics. The book attracted much comment and later editions incorporated points from correspondence or suggested additions, and de Styrap styled himself the “compiler” not the “author” of the Code.

In all editions de Styrap retained as the first chapter an address given by himself to the “Shropshire ethical branch of the BMA” in 1861. This piece of high Victorian rhetoric rehearsed the moral and spiritual hallmarks and rewards of medical practice. After describing the joy of patients’ recovering: “sun-bright spots in the oft clouded oasis of medical life” he came to the crux of his argument saying it was,

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3 de Styrap, Jukes, A Code of Medical Ethics: with remarks on the duties of practitioners to their patients, etc, (London, 1878), 3rd edn, H K Lewis, 1890, p. 6. This quote is from the preface to the first edition.
4 ibid., p. 2.
5 ibid., p. 5
sad indeed that the brightness of such a pictured mirror should be darkened by the shadow of our one great besetting sin, the bane of professional, as of social life - JEALOUSY - a spirit not only most inimical to our interests, but most derogatory to our manhood. ... until we are true to ourselves, true to the ethics of our profession, we shall always, in the eyes of the public, remain inferior to the other professions.⁶

De Styrap's answer to this problem was to enjoin each individual member of the profession to strive, each in his own little world, to live in harmony and good-fellowship, rivalling each other alone in good conduct and feeling, and be ever ready to lend a helping hand when such is needed, and, at the same time, by the impersonation of the scholar, the gentleman, and the Christian, so to adorn our lives and conversation, that whilst living we may be respected, and, when dead not one of our brethren shall have just cause to say that we have ever done him an act of prejudice, unkindness or dishonour.⁷

Thus de Styrap prefaced his very specific and detailed code (albeit riddled with such flights of rhetoric and tirades against Quackery) with this strong argument for a general ethical duty to do what was best by one's professional brethren and to maintain the high moral tone of the profession. Although most of the rules referred to doctor-doctor relationships, he maintained that "Medical (a branch of General) Ethics, to be effective must be based on the principles of religion and morality, and embody the reciprocal duties and rights of the profession and the public". De Styrap consistently stressed the importance of the devotion of medical men to the welfare of their patients - without regard for their reward.⁸

Although the Code is divided into numbered sections on specific problems it is essentially a long and often repetitive discourse. It dealt with, amongst other things, relationships with unorthodox healers, especially homeopaths, chemists and proprietary remedies. It also covered the need for veracity and consideration in consultation, the best ways of arranging consultations, along with advertising, and bulletins on the illnesses of the famous. The need for tact, secrecy, and sympathy, were stressed but the Code called for the consideration of the patient's feelings to be balanced with an assertive avowal of scientific truth. De Styrap also set out how a "Court Medical" could be arranged to settle a dispute. The single quality that marks de Styrap's Code out from Percival's is

⁶ ibid., p. 13.
⁷ ibid., p. 17.
⁸ ibid., p. 19.
its bullish assertion of the rights of the profession, serving as a reminder of how much first the
“Quackery scare”, the long campaign for medical reform and the establishment of the Register had changed things.

Robert Saundby, *Medical ethics*
1902, and 1907

Robert Saundby had a number of things in common with de Styrap, both were Midlands practitioners active in medical politics and especially in the BMA, but Saundby had far higher status. His work was also based on a great deal of practical experience, and was written in a far more sober and clear style. A fire destroyed the typeset of the first edition and thus the second, published after Saundby had resigned from the CEC, was completely rewritten.

In his preface to the first edition Saundby noted “whilst one or two published codes exist, but they deal with only a part of the questions which constantly arise”. Furthermore “it is not sufficient to say, as some people do, that medical ethics may be summed up by the Golden Rule, or that a man has only to behave like a gentleman; these are doubtless excellent principles; but there are numerous instances in which some definite guidance is needed.”

However, writing in 1907 he cited the Golden Rule and two other principles (all with suitably traditional Christian or classical roots) as being the underlying principles of medical ethics. Although Saundby felt it “no more easy to find a solid basis for medical ethics than for general ethics, which latter problem has puzzled philosophers in all times”, and presented his book as “merely an attempt to give expression to ... what may be called representative medical opinion”, he went on,

There are three principles which may be regarded as the cornerstones of medical ethics. In the relation of a medical practitioner towards his colleagues, he should obey the golden rule, ... “Whatsoever ye would that men should do to you, do ye even so to them” (St. Matthew, vii. 12); in his relations to his patients, their interests should be his highest consideration - “Aegroti salus suprema lex”; in his relation to the State, to the laws of his country, and his civic duties, there is no better guiding principle than the words of the Gospel, “Render unto Caesar the things that be Caesar’s” (St. Luke xx 25). ... The duty that

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a medical man owes to the profession of which he is a member is one of the highest he is called upon to fulfil.11

The book was organised into alphabetically listed topics, with glosses in the margins for quick reference. Thus it is easy to indicate the content of Saundby’s work. The longer sections were on advertising, club and contract practice, consultation, hospitals, patients, and confidentiality. There were several other areas in which topics can be categorised. Firstly ‘competence and therapeutics’, which included: alcohol, drug habit, euthanasia, induction of premature labour (abortion), malpractice, marriage (eugenics), new remedies, pregnancy in unmarried women, prognosis, reading and study, and surgery and operations. Many of these sections were very short.

Another very large area was ‘relationships with unqualified practitioners’ which included, bonesetters, chemists, dentists, masseurs, masseuses, electricians and radiographers, nurses, midwifery and midwives, opticians and quacks in general. ‘Trade, and distancing doctors from it’ formed another large group of subjects encompassing: dispensaries and private clinics, doctors shops, patent foods and medicines, patenting surgical instruments, the sale and purchase of practices, and secret remedies.

Saundby discussed the legal and statutory ramifications of the increasing involvement of the State and large employers in medicine. Thus subjects like certificates, employers liability, factory surgeons, life insurance, medical officers of accident insurance companies, referees of railway cases, Medical Officers of Health, Public Vaccinators, Medical Officers of the Poor Law, military medical services, notification of disease, and the Workmen’s Compensation Acts were included. Other related medico-legal topics included giving evidence in courts of law, the obligation to attend when summoned, post mortem examinations and coroner’s inquests.

However much of the book was given over to matters of internal medical politics and doctor-doctor relationships. Here subjects included the position and obligations of assistants, commissions (dichotomy), consultations, the courtesy title “Doctor”, the medical etiquette of visiting colleagues, fees gratis attendance on medical men and other professionals, other gratis patients, partnerships, resigning cases, seniority, supersession, the courtesy call, and visits to patients.

11 Saundby, Robert, Medical ethics, a guide to professional conduct, (2nd edn.), London, Charles Griffin, 1907, p. 1.
William G Aitchison Robertson, *Medical Conduct and Practice, a guide to the ethics of medicine*

1921

In Robertson’s work we find a much more discursive book of advice for young practitioners. It has proved difficult to discover anything much of this writer, beyond the details he gave in his book. Robertson taught medical jurisprudence at several Scottish Universities, but he does not appear, in contrast to the previous two codifiers, to have had their kind of “case experience”, or any connection with the BMA. Since the book did not run to a second edition I have not given a great deal of emphasis to it, here or elsewhere. That said, Robertson’s discussion of what medical ethics was and what it might be is much more philosophically grounded than either de Styrup or Saundby’s. (It is difficult to know if this reflects different styles of teaching in Scotland, or a different style of medical ethics altogether.) Ethics was based on the Aristotelian concepts of and, he said

concerns itself with what one ought to do, and consequently investigates the nature of duty and deals with what is right and wrong in conduct ... It also studies what one ought to be, and as a result of this it endeavours to build up a scheme of virtues by means of which the character may be formed.

In public health specifically he stated it was based on utilitarian ethics. Yet he would not be dealing with abstractions since, by and large

By medical ethics is meant that body of rules and principles concerning moral obligation, which is intended to regulate medical practice. These rules have not been drawn up by any body of medical or other men, but have for so long a time received the unanimous assent of the medical profession as a whole that they have become binding on each individual member.

Thus even Robertson writing from the Scottish perspective adopted an approach to medical ethics based on precedent and usage.

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12 Robertson was evidently an Edinburgh man all his life. He qualified MB CM in 1887, and during the early 1890s qualified DSc BSc FRCP (Edin.) and MD. He was lecturer in Medical Jurisprudence and Public Health at the Royal College of Surgeons of Edinburgh, and Examiner in these subjects for the RCP of Edinburgh, and both Edinburgh and St Andrew’s Universities. He had worked as resident physician to the Royal Maternity and Simpson Memorial Hospital, and was Physician to the Royal Public Dispensary and clinical assistant in the Medical and Gynaecology departments of the Royal Infirmary. He also published a *Handbook of Clinical Diagnosis*, a *Manual of Medical Jurisprudence and Public Health* (3rd ed. 1916) and in the journals on milk supply, cancer topography, and tests for blood. He disappeared from the *Medical Directory* after 1919.

Robertson’s book dealt with medico-legal questions like court appearances, negligence, and the law surrounding lunacy, and traditional medical ethical topics like advertising, secrecy and sick room etiquette and consultation. It was also very much concerned to promote a type of moral character for the reader, and to advise on the best way to succeed in practice. His advice was always to take the moral high ground, and to shun short cuts that harm fellow practitioners or patients.

Voices from the past

W H S Jones, *The Doctor’s Oath: an essay in the history of medicine* 1924

This little monograph by the bursar of St. Catherine’s College, Cambridge was a collation and translation of all the existing versions of the Hippocratic Oath, and a review of other Hippocratic writings on medical conduct. Jones thought that the Hippocratic corpus contained “noble rules of conduct, loyal obedience to which has raised the art of medicine to the high position it now holds”. He subscribed to the idea, popular with some doctors, that medical ethics was an ancient and continuous tradition saying, “at the present day medical ethics and medical etiquette are based on [the Oath]”. Jones was not starry eyed however, and noted that “it is clear that Oath binds the apprentice to a society approximating to a guild or trade union”. Sadly he did not comment on the medical ethics and trades unionism of his own day.

Certainly his summary of the basic rules of “ancient medical ethics” contained a number of themes that are very familiar in the materials studied for this thesis. He summarised them as indicating that a doctor ought not to give poison or suggest giving it; cause abortion; abuse his position by indulgence in vice; to tell secrets, however acquired; to advertise (he took this from *Precepts XII*, “on lectures”); or operate (which he characterised as a later rule). He also found that this ancient literature indicated that a doctor ought to call in a consultant when necessary, and act as one when asked, not charge beyond the patient’s means, and be clean, well mannered and dignified. There was, he said, no injunction to share important knowledge or skills, but felt that the Oath implied this. It seems quite likely that Jones knew quite a lot more than he indicated about contemporary medical ethics, and was alert to the parallels and changes he was outlining.

15 ibid., pp. 132 - 40.
16 ibid., pp. 78 - 91.
18 ibid., p. 51.
Chancey D Leake, *Percival's Medical Ethics*, and its reception

Chauncey Leake's consideration of the legacy of past codes of medical ethics was far less sympathetic. As we have seen, his edition of Percival's *Code of medical ethics* was published as a vehicle for his damning critique of it, and the American codes derived directly from it. Leake made the argument that these were not ethics at all but a code of etiquette masquerading as a statement of principles and ideals and basically designed to protect the "hedonistic" interests of doctors.

The *BMJ* reviewer of his book criticised it for purporting to examine the "origins" of medical ethics whilst failing to "go far enough back" (I presume this meant to Hippocrates). Although the identity of this reviewer is unknown his comments are an interesting defence of the ethical framework of medicine of the times.

Something may doubtless be said on the verbal issue between "ethics" and etiquette, but here we have no hesitation in maintaining that all professional rules and customs must in the end justify themselves by the sanction of the public interest; and we believe that this sanction is not wanting. Professor Leake ... contemplates the medical practitioner as drawn in one direction by the temptations of his own pocket, and in the opposite direction by the welfare of the patient, and almost inevitably deciding for the former, seeing that "true idealism is impossible in existing conditions". This of course is to reason *a priori*. A certain propensity of human nature is assumed ... motives and decisions in life are not quite so simple as this reasoning implies.²⁰

He went on, apparently unaware of any irony, that it was as unsound to argue that doctors did not wish "to see mankind in perfect health" as to argue that lawyers did not wish litigation to cease, soldiers war, policemen crime or parsons impiety. The point was, he said, that "it is the existing situation, not some remote development, that governs conduct" and the doctor has a choice either to take advantage of ignorance and helplessness and emotional susceptibility [or] to follow decent, natural human instincts and professional traditions and pride in craftsmanship. When as we believe is almost invariable, the doctor takes the straight course, he does not boast the "nobility" of his action, or label it "idealism" or urge his "concern for the ultimate welfare of society". He has a much simpler explanation, and this he prosaically terms "playing the game".²¹

This reviewer was at pains to point out the understated and untrumpeted decency of (British) doctors, as against any overt or strenuous (and thus quackish) claim to the moral high ground.

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²¹ *ibid.*
C O Hawthorne on Medical Ethics in *Practitioner*, 1936.

Hawthorne echoed this theme in an article for *Practitioner*’s series on general practice in 1936. Given limited space Hawthorne chose to cover advertising, secrecy, “intra-professional” duties, consultation and supersession (that is, taking over a patient’s care from another doctor). But it is his general comments that were most striking, especially given that he stated that the “popular view” of medical ethics was that they were designed to line doctors’ pockets. His defence against this charge is the most coherent I have found written by a member of the CEC. He said,

> Medicine is a profession and not a business enterprise, and ... those who practice it are not mere rivals for popular favour or for commercial success. ... As a form of social service medicine must put in the first place the interests of the community, but this end will not be promoted by the cultivation of undignified competition or enterprising self-advertisement; indeed, the greater aim is promoted, not hindered by the recognition of individual duties, rights and mutual responsibilities. It is in order to adjust these two positions, the general interest and the individual claim that there exists a code of directions or advice, to a large extent unwritten, that may be spoken of as a body of medical ethics. ... Essentially they mean first of all the welfare of the sick man, and secondly the practice of the golden rule of all intra-professional relations.”

Even then he thought, most doctors needed no guidance,

> it is not unpleasing to reflect that many practitioners, perhaps the majority, have without any acute consciousness of written rules practised their profession for many years with the unfailing regard and goodwill of their neighbours. They have cultivated medical ethics by instinct and good nature rather than by rule and authority

Thus, for this eminent Victorian, medical ethics were still part of the natural order of society and British culture and could be easily adapted to the ethos of public service, and were essentially instinctive to many doctors.

**Guidance in Practice**

**BMA Handbooks for Medical Practitioners**

Despite this faith in the inherent sportsmanship and gentility of doctors the BMA, if not always the CEC, pushed for more advice to be made available to doctors, especially the newly qualified. Here I shall trace the content and changes to the *Handbooks* of 1923, 1926, and 1935, which included the GMC’s Warning Notices in later editions. I have already described the provenance of the

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23 *ibid.*, p. 656.
Handbooks, and shall say more about the BMA's agitation for the Warning Notices on advertising in a later chapter. They formed part of a quite large literature on the practical side of medical practice and medico-legal issues.

In the first edition of the Handbook for Recently Qualified Medical Practitioners ethics, under the title, "Duties Of Medical Practitioners", were separated from medico-legal advice, the two sections being prepared by (probably) Macpherson, the Deputy Medical Secretary, and W A Brend respectively. The content of this ethical section is worth examining briefly. It opened with the Hippocratic Oath, and then dealt with "the duty of the doctor to his (or her) [sic] patient, the duty to his profession, the duty to the community, and the duty to his family and himself." This first section stated that the two main principles of medical ethics were "that with the doctor the interest of his patient comes first, and nothing can be allowed to interfere with it" and "that we should do to others as we would wish that they would do to us".

However when these duties to patients were spelt out in detail they were: not to consult with the unqualified, not to take over patient’s without involving the previous doctor, not to endorse or have an interest in any medical appliance or preparation, and to use the locally agreed scale of fees! The second section basically argued that it was better to "play the game" than to compete, and that all doctors should join the BMA. This would then help the practitioner confronted with conflicts of interest between patient, doctor and community discussed in the third section; the Honorary Secretary could advise you. Lastly the doctor had a duty to secure a pension and to join a medical defence organisation. It must be borne in mind that the Handbook was pursued primarily as a recruiting tool, but what is most striking about this short section is that it is only marginally less subtle in its underlying assumptions than de Styrap, Saundby or many other statements by those involved in medical conduct and discipline.

The 1926 and 1935 editions, perhaps on the advice of Langdon Down, and in keeping with the Lancet articles discussed below, blended the two sections into "Some practical aspects of Medical work". Here problems were listed alphabetically, and where these were primarily ethical often used resolutions or rules of the CEC as their basis. The Hippocratic Oath was still included, but kept company with subjects like advertising and canvassing, commissions and dichotomy, consultations,
courtesy calls, degrees and qualifications, doorplates and the title “doctor”, fees, supersession, professional secrecy (examination and consent) proprietary articles and secret remedies. The appendices included the latest versions of the GMC Warning Notice, and the BMA’s Rules of Consultation. (see chapter 7.)

The GMC Warning Notices

The content of the Warning Notices varied over time (many of the changes are discussed later) so here I shall describe a later version of them, reproduced in the 1935 Handbook. The Notices opened with Section 29 of the 1858 Act giving the GMC power of erasure, and went on “it must be clearly understood that the instances of professional misconduct which are given below do not constitute, and are not intended to constitute, a complete list of the offences which may be punished by erasure …”

The first Notice related to “untrue, misleading or improper” certification and gave a long list of the various organisations requiring certificates and the Acts under which some were required. The second related to unqualified assistants and “covering” unqualified practitioners, the first kind of offence to be published in a Notice. The third Notice was about the sale of poisons, specifically in shops owned by doctors that used unqualified persons to sell poisons direct to the public. The fourth Notice related to the Dangerous Drugs Acts, which gave medical practitioners the sole right to hold certain narcotic and other addictive drugs under certain conditions. The publication of this notice was the first one that actually preceded a case of an offence before the Council. The Fifth notice was a specific extension of the second, and related specifically to any “assistance” “by administering anaesthetics or otherwise” of an unregistered practitioner in the treatment of patients. The sixth Notice concerned Advertising, either directly or indirectly, or Canvassing, which had been the second kind of offence published in this way. Lastly “association with uncertified women practising as Midwives” was forbidden.

**Squire Sprigge et al. *The conduct of medical practice***

1927, 1928

This volume was a reprinting of a series of articles by Squire Sprigge and others from the *Lancet*, which ran to two editions in rapid succession. Among the contributors were Norman King, Registrar of the GMC (his 1926 *Memorandum* appearing almost verbatim), James Neal, Oswald Hempson, and Hugh Woods of the MPS. Sprigge stated that it dealt “with the conduct of medical practice, and not with the conduct of practitioners ... [it] does not pretend to be a manual of ‘medical etiquette’.” Indeed Sprigge felt that written codes “had their danger when wrongly used ... when a practitioner insisted in regarding them as laying down regulations by which the public must be guided, whether in the public interest or no, trouble always occurred.” Many of the topics included were extremely practical and examined from a practical and legal point of view. That said the book went on to deal with a number of issues that were also dealt with by the CEC particularly advertising and professional secrecy,

In Part I, “The Medical Career”, Squire Sprigge discussed The Golden Rule in relation to other doctors, the contrast between the professional and commercial attitudes and the general practitioner’s needs; three of the underlying themes of contemporary medical ethics. He then moved on to discuss medical education and the choice of career. The book dealt exclusively with General Practice thereafter “because the GP’s professional life is more difficult at the outset, has more legal and statutory ramifications, and is more often beset by litigation or the need to testify.” Thus locum and assistant posts were discussed in great detail often involving ideas and principles that formed the backdrop to ethical disputes, along with a discussion on the Transfer of practices

The book went on to blend a number of themes. James Neal discussed the doctor patient relationship including the “relation of contract”, the importance of consent, and advice on negligence, dichotomy (fee-splitting) and gifts. Hugh Woods provided a chapter on another medical ethical topic, secrecy. Following chapters on Panel practice and the certification of Panel patients There was a section on “statutory obligations and professional discipline”. This described

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30 Sir Samuel Squire Sprigge, (1860 - 1937) was the son of a country doctor and land owner, and was educated at home, Uppingham School, Caius College Cambridge, and finally St. George’s Hospital, who appears to have found medical practice uncongenial. Following a period working as a private secretary he became assistant editor of the *Lancet*, in 1892. He was its editor from 1907 until his sudden death in 1937. Primarily a man of letters, Sprigge was very interested in medical politics and also in medical education, which he felt should be more general and less burdened with detail. *Br. med. J.* 1937, i: 1346, *Lancet* 1937, i: 1550.


32 *ibid.*, p. 9.
the GMC and the scope of the Warning Notices and then went on to cover the themes of each Notice in detail, giving a chapter to each. A section on Medico-legal situations was largely contributed by Hugh Woods, and covered medical evidence, the doctor and coroner, libel and slander, actions for damages and poisoning and suspected poisoning. The last section detailed medical work in the public services, including the fighting services, the Colonial Medical Service and the various civilian public services.

Thus whilst not setting out to be a text on medical ethics a number of such themes were in fact included in the book demonstrating the way in which medical ethics and medico-legal advice were blended in an “advice literature”. Another point that comes out in this literature is the way in which the idea of consent is discussed. In this literature it is almost always discussed as a medico-legal issue, and a matter of prudence, and this is in marked contrast to the way in which consent is now construed as an ethical issue flowing from a respect for patient autonomy. Where consent is discussed in a more ‘ethical’ way it is in the context of secrecy and breaching it; a topic considered at length in Chapter 12.

**The medico-legal literature**

**Medical jurisprudence texts**

I have examined two very long running textbooks; *Medical Jurisprudence* originally by Alfred Swain Taylor, and *A textbook of Medical Jurisprudence and Toxicology*, originally by John Glaister. Both books were focussed on forensic matters like wounds, poisons, modes of death and legal categories of injury and offences against the person. Taylor, who defined the subject as “that science which teaches the application of every branch of medical knowledge to the purposes of the law” pointed out in 1910 “Medical Jurists are by no means agreed upon the boundaries of their science”. Thus a number of “ethical” questions with medico-legal ramifications were considered. These included abortion, quackery and the GMC (the law concerned being the Medical Acts) and professional secrecy (which centred around the powers of the courts and the risk of charges of slander or libel), malpraxis and crimes against the person. The advice found here - much

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of which will be quoted in detail in the relevant chapters did not differ significantly from the advice or opinions evident in the work of the CEC.

As sources of ‘ethical advice’ much was missing, the discussion of doctor’s relationships with other doctors, consultation, and advertising, along with any discussion of the basic tenets of ethical behaviour. These texts stayed always in sight of the ‘coastline’ of case-law and forensic science. Anne Crowther’s opinion that ethical content of these works as “a marginal part of a marginal subject”\(^{36}\) is borne out by this and the fact that organisations like the BMA felt the need to inform doctors of the ethical content of these standard textbooks.

The medico-legal literature

I have not undertaken a thorough reading of the medico-legal literature of the period, but two books bear out the relationship between medical ethical topics and agendas and medico-legal ones, even given the steady growth in the number of laws affecting medical practice throughout the period. Lord Riddell’s *Medico-Legal Problems*,\(^{37}\) covered the legal responsibility of the surgeon - but largely dealt with the problems posed by operations involving the reproductive organs like vasectomy and female sterilisation, the sterilisation of the “unfit” and abortion. Derek Kitchin’s *Law for the medical practitioner*,\(^{38}\) whilst explaining the types of negligence cases that went against doctors, also dealt with topics like secrecy, informing the authorities of crimes, especially abortion, the GMC, and the law relating to slander and libel.

Two features distinguish these works from the literature described in the rest of the chapter. Firstly they deal with legality not morality, and stick largely to issues at law or in statutory arrangements. Secondly the whole group of topics relating to the differentiation of the doctor from the quack and tradesman, (like advertising and covering,) and the relations between doctors (like consultation) were not covered.

The Medico-legal society

I have not researched the history of this organisation, which is still in existence. During the interwar period it appears to have been a lively forum for meeting and debate between medical


practitioners, medical practitioners with legal qualifications and lawyers. A number of papers given at the society printed in its journal Transactions of the Medico-legal Society (later the Medico-legal and Criminological Review) are cited later in this thesis. Several figures involved in medical ethics and medical defence were members, including, Robert Bolam, W A Brend, Reginald Langdon-Down, C O Hawthorne, James Neal, William Aitchison Robertson and Squire Sprigge.39

Discussion

A number of points raised in this literature explain its small size. Firstly, whilst written discussions were felt to be useful, medical ethics was seen to be something that could, or perhaps even should remain unwritten. Indeed the decision of the BMA to remodel their "duties" and "medico-legal sections into one of 'practical advice' may indicate a reluctance to spell too much out. Medical ethics, dealing as it did with what practitioner's "ought to do" was bound have a large overlap with the laws relating to medical work, which embodied societal injunctions and instructions on this question. Medical ethics could thus be characterised as a discussion of what the doctor ought to do but argued not so much from law and practicality, as from a set of very simple moral rules: "do as you would be done by", and "do what is best for your patient". Medical ethics dealt with behaviour within the professional pale, whilst the law represented an agreement with those that lay beyond it. Medical ethics was not so much a canon of rules as a sense of how "the game" should be played. In medical ethics one appealed to the umpire perhaps, in medical jurisprudence it was more a question of calling in the police. The BMA, as we shall see, set out to provide a whole system of 'umpires'.

39 Transactions of the Medico-legal Society 1922 - 23, XVII: vii - xx
Section II

The Ethical Issues
Chapter 6

The Ethics of Appointments and the general Ethical Rules

Introduction

This chapter will describe the development of two sets of closely related rules, regulations, obligations and other devices. The first was a general set of rules, later known as the Ethical Rules of Procedure, which outlined the way in which disciplinary cases and disputes should be settled locally. The second was a specific set of rules and resolutions, along with a “Warning Notice” in the BMJ, which concerned the holding of appointments that local medical men had decided were “contrary to the honour and interests of the medical profession”. Since at the time these sets of procedures were introduced many local disputes were about contract practice, the distinction was not as great as might be supposed. In combination these provided the BMA with a “machinery” with which to pursue its medico-political agenda on doctor’s appointments. Although Squire Sprigge protested against public perceptions that the medical campaign on contract practice was “a design upon the part of certain operatives banded together by a mysterious tie called medical etiquette, to strike for higher pay”¹ this impression was not entirely at variance with the facts.

The rules were developed in the 1900s, drawing on local rules and ideas, some predating the new BMA, and were gradually changed and standardised in the 1910s and 1920s. Many of the changes were remarkably modest responses to instances in which the “machinery” was misused or misunderstood in ways which resulted in expense and public embarrassment for the Association. Despite this, and the demise of much lay-organised contract practice with the introduction of National Insurance, this “machinery” was retained and occasionally used at the outbreak of the Second World War. This was partly because whilst the original impetus for the specific procedures on appointments came from the drive to reform contract practice, they were very soon applied to some hospital appointments and public health appointments under local authorities as well.

¹ Sprigge, Medicine and the public, 1905, p. 240.
The "Bradford Rules" on appointments: a contract practice boycott scheme

Roots in professional culture and local medical opinion

The broad objections to contract practice, and the idea that doctors who took disputed posts were offending against professional honour and solidarity, have been introduced in Chapter 2. However, it is worth examining some of the early comments and resolutions made on the issue in a little more detail. The columns of the medical press were full of correspondence and articles on contract practice and disputes around the country, and local BMA meetings were treated to rousing addresses on the subject. One speaker described contract practice as an "unmitigated evil" which entailed "an ever-increasing tendency to the reduction of our earnings to a mere living wage" whilst "the artisan" on the other had now enjoyed "a degree of prosperity hitherto unknown. Combination [trades unionism] has greatly increased his earnings ... the working class patient is to-day more capable than formerly of appreciating careful treatment, and paying for it."3

Club medicine was held to be cheap, hurried, demoralising and dangerous by another speaker who asked,

how can a medical man visit 40 or 50 patients a day, many of them very ill, diagnose their ailments, sign their certificates, and give general directions as to diet ... when perhaps he has to travel three miles in [each] direction ...? ... It speaks well of the physical and mental capacity of the club doctor that more calamities do not take place.4

Part of the tension involved in such contracts was that doctors were often paid capitation inclusive of drugs and appliances. One doctor complained that he was expected to pay for all medicines, splints, plasters, appliances and medicines from the capitation money of 1/2d. per patient per week. (2s. 2d. per annum).5 The lack of any wage limit on those eligible for Friendly Society membership directly cut back the available population for private practice. This was felt keenly by many doctors, as comments made in response to the BMA's survey of contract practice undertaken in 1903 revealed,

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2 Following as "The Battle of the Clubs" in Cork in 1894 the Lancet started a regular column under the same title, and employed a special correspondent, Adolphe Smith, to travel around Britain reporting on other local contract practice disputes. The BMJ also ran regular columns entitled "Contract Medical Practice" from 1900 onwards. (Contract Medical Practice, Br. med. J., 1900, i, p. 928.)

3 A Bailie McKnee, "Contract Practice: the evil and its remedy" (an address read before the Bath and Bristol Branch of the BMA), Br. med. J., 1902 i: p. 330.


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I have one man among my club patients who made a profit of £30,000 on a public house and who owns acres of houses [sic] in this district. ... [such] men value their doctor at 1d a week, not the price of a decent cigarette, numbers of which they consume daily.6

[the society admitted] farmers and tradesmen, shopkeepers, publicans etc., who obtained medical attendance for 5s. a year, but did not care to “trouble the club” that is, to draw 10s. or 12s. a week, but considered that they ought to get medical attendance for the same price as one of their labourers, and generally fussed more, and thought they ought to have more attention shown to them than the poorer members.7

Class consciousness pervaded medical objections to the situation. One doctor, working in Nottinghamshire, was prompted to write by reports of a speech by a miners’ leader, which spoke of their 60% increase in pay over 13 years. The miner’s speech, he said, made “very interesting reading for the medical men in the Teversal district” and concluded that doctors could learn from the trades union methods adopted by such employers, pointing out,

... [these miners] are the same men who in 1896 reduced their club doctors salary [sic] by 1s. per head per annum, and 1901 dismissed them when they refused to attend their wives in confinement at a rate 50% below that current in the district. ... working men are frequently most tyrannical ... argument does not appear to have much effect ... if the medical profession wants justice it will have to fight for it, and by strong combination show the workmen’s associations that it is able to follow their example.8

Alfred Cox, as we have seen, had come to much the same conclusion, saying, “I had become friendly with some of my patients who were keen trade unionists and I began to ponder why we should not adopt some of their methods.”9

Many correspondents identified the ease with which clubs could replace doctors as the main obstacle to reforming contract practice. The apparently successful strategy adopted in Cork was a unified refusal “to meet [the imported men] as professional brethren”.10 Refusal to meet incomers appeared to need only a little encouragement, since many correspondents described them with disdain. One correspondent commented “whenever there is a medical battle on the club question

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7 ibid., p.7
9 Cox, Among the doctors, 1950, p. 68.
10 Sprigge, Medicine and the public, 1905, p. 53.
these men suddenly appear from outside having the same mysterious perception of a cheap club that a vulture has of a dead body."  

Many had practical suggestions to make. For instance one Sheerness doctor urged any readers interested in a particular post in the town to contact him first. Others pressed for a systematic survey of contract practice. Many were of the opinion that only total medical solidarity could break the control of Friendly societies. One correspondent signing himself “Unionist” suggested that “due warning” should be given in medical press of posts offered by offending Societies, and any man “showing any inclination to accept …[should be] … waited on by a deputation from the medical men, and the facts fully explained.” He went on

should any medical man have the temerity to accept it after this warning, I would do more than merely ostracise him, I would boycott him. Ostracism would affect this class of man very little, having no esprit de corps, he cares nothing for his professional brothers, and he would find other associates more to his taste. But a real, active and aggressive boycott would be different. … If the profession means to really fight this question, this is the way to begin."  

Medical men were financially and socially threatened by contract practice and claimed that it eroded standards of practice. In common with all self-respecting groups in Edwardian Britain, doctors were keen to use association, combination and esprit du corps, which in working class hands was termed Trades Unionism, to further their cause.  

A task for the new BMA

Against this background Alfred Cox proposed an important composite motion at the first ARM in 1902. It outlined a whole field of medico-political activity, and stood out from the generally minor or procedural nature of other motions at the meeting. It instructed the Medico-political Committee (MPC) “to investigate the economic conditions of contract practice” and the Ethical Committee

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15 Harris, Jose, Private lives, public spirit: a social history of Britain, 1870 - 1914, Oxford, OUP, 1993. Harris stresses the way in which every group in British society was concerned to imitate those classes above itself, and differentiate itself from those below. Thompson, F M L, The Rise of Respectable Society: A social history of Victorian Britain 1930 - 1900, London, Fontana, 1988. Thompson has stressed the importance of respectability to all social classes in Britain, ascribing the stability of British society largely to this factor.
to investigate the ethical position of medical men engaged in various kinds of contract
practice with reference to a) the amount of canvassing associated with the several varieties
of contract practice; b) the ethical position of medical men who accept or continue to hold
appointments which the general body of medical men in the locality have agreed not to hold
on the ground that the conditions of tenure are detrimental to the honour and interests of the
profession

He also called for the Secretary to take part in settling contract practice disputes, and for the BMA
to put up representatives for election to the GMC. 16

In effect there was little difference between the CEC’s role as an advisor on rules drawn up by local
branches, and the task set by Cox’s motion, since much of the committee’s work at this time was
taken up in considering the ethical rules proposed by Branches and Divisions. 17 Local Divisions
drafted rules on appointments that reflected the notions of solidarity and personal obligation to the
group. A typical example was one proposed by the Norwich Division, which stated,

a member of the Division shall not undertake in future any fresh contract practice, direct or
indirect at a lower rate than the public medical service, or accept any appointment in any
Medical Aid or similar Society, or have any professional intercourse, except under
conditions great urgency with any medical man holding a position with any society held by
the division to practice touting or canvassing, or sweating their medical officers. 18

Other Divisions decided that the action need not only apply to BMA members: the Gateshead
Division suggested the ostracising of any expelled member. 19 The Bradford Division drafted a set
of rules that presented these essential features in a much clearer form, and they were adopted and
promoted by the Central organisation. 20

The “Bradford Rules” on appointments (1905)

Although these rules were later incorporated in the standard set of model rules for Divisions and
Branches, I shall describe their original form here. Rule A allowed for resolutions of the Division
to be “binding” on all members, provided the conditions set in rules B and C were met (3/4
members voting at a meeting with 14 days notice to attend). Rule D referred to those holding
disapproved appointments, who were to be given formal notice of the Divisions resolutions, and
given one month in which to comply with the Division’s wishes, unless they could satisfy the CEC

16 ARM 1903 minutes 22 - 25.
17 Report, Council, 28 - 31.7.03.
18 Report, Council 28 - 31.7.1903
19 Council, 8.7.1903
20 Br. med. J., 1905, ii: supplement, pp. 95 - 6
of the propriety of their actions. Rule E stated that the Division “shall” ask the Branch to request the expulsion of any member who had broken the rules or whose conduct had been “detrimental to the honour and interests of the medical profession”. Rule F was titled “Refusal of professional recognition” and provided “the means by which the Division may mark its disapproval of the action of members of the profession whether members or not” [italics added]. This was achieved by stating that no member “shall ... meet in consultation, or hold any professional relations” with a practitioner who had broken the rules, or whose conduct was “detrimental to the honour and interests of the medical profession”. (Non-members were given one month’s notice - presumably to allow them to mend their ways - before this came into effect.) Whilst members could meet an ostracised doctor in cases of “great urgency”, Rule G aimed to “prevent abuse of the exception”, by asking any member who did meet such a doctor to report on this meeting to the Division Honorary Secretary. Unsatisfactory reasons could of themselves be held to constitute conduct “detrimental to the honour and interests of the medical profession” and deserve ostracism in turn.21

As if this were not enough, a further Rule, ominously (and perpetually) named “Rule Z” was devised by the CEC, in response to suggestions and in order to “give proper effect to the[] decisions ... of Divisions” in 1904.22 This rule allowed the Division Hon. Secretary, after applying for sanction to the CEC, to issue a notice to all members of the Division stating that in the Division’s opinion the conduct of a particular doctor had been “contrary” or “detrimental to the honour and interests of the medical profession”. This removed any possibility that a member could escape his duty to ostracise through ignorance of the identity of the ostracised doctor.

This set of rules thus allowed a 3/4 majority decision of a group of local medical men to declare the holding of certain appointments (or even simply the behaviour of a practitioner) to be “contrary to the honour and interests of the medical profession”. Once in place such a resolution entailed all the members in systematic ostracism that they could only break at peril of the same fate for themselves. It was also possible for one Division of the BMA to communicate its ostracism of any doctor to any other branch or division of the Association and these Divisions could then also participate in the ostracism of that doctor, and of any doctor who met with him. (For an example of this - see the Coventry case, below.) The underlying “ethical” principle (aside from the generic objections to contract practice’s use of advertising, canvassing etc.) was that the member of the Association and

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21 The terms ostracism and boycott are used confusingly in the literature. Unless quoted I use the word “ostracism” to indicate the professional isolation of an individual doctor by his colleagues, and the word “boycott” to indicate the systematic application of this to disputed appointments.

22 CEC, 18.3.1904.
the member of the profession alike owed a duty to the Association or profession not to act to injure its honour or interests. Ostracism was supported by Whittaker Smith, by then Secretary of the BMA, who thought it in keeping with “the general principles of Medical Ethics”.23

The social and professional isolation that the rules entailed had far reaching implications. A practitioner relied heavily on others to act as “consultants” on difficult cases, or on other more eminent colleagues to provide surgical skills and other special expertise (see Chapter 7). The ostracised doctor could thus be left to practice his profession without medical support of any kind, quite apart from the social stigma and day-to-day unpleasantness of being made a pariah.

The BMJ Warning Notice

This is the first of many instances in this thesis in which the advertising function of the Journal was central to efforts to control the conduct of doctors and the organisation of medical care. The new BMA constitution had solved one aspect of the “incomers” problem by ‘automatically’ making each member of the Association a member of the Division in their area. But it was also felt to be important to warn off potential applicants to unsuitable or disputed posts. The CEC had in 1903 been asked to consider the complaint of a local Division that appointments had been filled by doctors “ignorant of the facts”. They had suggested using the Journal, where many doctors would look for advertised vacant appointments as the medium by which the information or warning was to be propagated. The CEC drafted regulations for such a notice, and Council approved the idea in 1903.24

The Notice was placed amongst the advertisements, a fact that has rendered it “invisible” to those looking at the BMJ today, since bound series did not include the extensive advertising material, although small notices directing attention of readers were placed in the main journal.25 The Notice itself consisted of a request for practitioners considering candidacy for appointments in the areas listed to apply to the Hon. Secretary of the Division, listed opposite each area, before proceeding. It was signed by the Medical Secretary, and bore the rider “by order of Council”.26 The original

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23 CEC, 18.12.1903.
24 Council, 1.10.1903
26 Memorandum, Conference of Chairmen of Committees as to the Warning Notice 22.4.1908, thereafter Warning Notice Sub-committee (hereafter WN s/c).
Notice had referred specifically to Club and Contract Practice appointments, but in 1904 on the Council agreed to extend its use to Poor Law and Sanitary Authority appointments.\(^{27}\)

The regulations governing the Notice were comparatively simple: the Hon. Secretary of the Division could apply to insert a Notice, the Medical Secretary was responsible for keeping the list up to date, and for ensuring that the regulations had been complied with. A fresh application had to be made each month to retain the Notice.\(^{28}\) Despite subsequent protestations to the contrary, the Notice was widely regarded as a “black list”, even after it was renamed the “Important Notice” in 1914.\(^{29}\) The form and regulations for the Notice changed frequently but its basic function was never to change - it was there to enable local Divisions and the Association to ensure that applicants to disapproved appointments were *au fait* with local opinion and other general objections before applying.

**The Investigation into Contract Practice, 1903 - 5**

1905, whether by design or accident, was the year in which the boycott scheme crystallised. A permanent Contract Practice sub-committee (CP s/c) was formed which met between six and eight times a year over the next few years and monitored the progress of various disputes around the country as well as advising local groups of doctors.\(^{30}\) A central Emergency Fund was also set up to support local Divisions in disputes, and the Association sent out a letter asking members to contribute to this along with their subscription renewals.\(^{31}\) The GMC published its *Warning Notice* outlawing many methods used by friendly societies, the *BMJ*’s own Warning Notice indicated where posts had been designated for boycotting, the Bradford Rules allowing organised ostracism were approved, and the MPC’s “very voluminous” “Investigation into the Economic Conditions of Contract Practice in the United Kingdom” was published.\(^{32}\)

This is not the place for a detailed discussion of this document, which formed part of the BMA’s negotiating strategy for many years. (It was submitted to the Royal Commission on the Poor Laws, and was used to fight the National Health Insurance Bill.) However, read dispassionately it also shows how weak the support for the BMA’s stance might be. The most important points in this

\(^{27}\) Council, 20.4.1904.

\(^{28}\) Memorandum, WN s/c 22.4.1908.

\(^{29}\) *Br. med. J.*, 1918, ii: supplement 26.10.18, p. 60.

\(^{30}\) MPC, 3.1.1906.

\(^{31}\) CP s/c, 18.11.1908.

respect were that the response rate to the questionnaire was poor, that it failed to demonstrate a large disparity between contract and private earnings, and that many respondents were quite happy with their posts, or simply wanted their rates of pay increased.  

Despite this the Medico-political committee felt able to recommend on the basis of the survey “effective abolition” of contract practice. The “fundamental principle” of the Report’s recommendations was “that the conditions upon which medical practitioners in any district should undertake contract practice should be prescribed by themselves”. Each district should have a Public Medical Service, “the general control of which should be in the hands of an organised local body representative of the profession, such as a Division of the BMA”. The Report set out model rules and regulations for these, as well as for Provident Dispensaries. Broadly these outlined that such organisations were to be entirely controlled by a committee of the medical men working within the organisation. Public Medical Services were to be open to all local doctors, and patients should be free to chose a doctor within it. In this way contract arrangements would approximate to the conditions of private practice, whilst ensuring that any who could afford true private medicine were excluded from the system. (Similar arrangements were key to the medical acceptance of National Health Insurance.)

The report ended with a section dealing with “The Ethical Aspects of Contract Practice”. This section stated that in the CEC’s view, there were two ethical questions connected with contract practice. The first was the advertising and canvassing undertaken for contract practice. The second was “the obligation resting on practitioners to co-operate with their fellow practitioners in improving the conditions of Contract Practice locally”. This section went on to state that “the Council, on the advice of the Committee, has laid down the principle that members of the Association should loyally co-operate” in such action since “the effects of contract practice [are] not confined to those actually engaged in it.” The Bradford Rules were set out and their use in contract practice disputes explained.

Operating the boycott scheme and early changes

From its inception the scheme was widely used, and regarded as being useful and satisfactory. During 1906 the CEC received and approved applications to circulate Rule Z notices from several

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33 *ibid.*, p.27.
35 MPC, *Investigation into ... Contract Practice*, 1905, p. 29.
36 *ibid*, pp. 95 - 96.
divisions. In 1907 the CEC in its report to the ARM urged the uptake of the model ethical rules, and particularly the Bradford Rules by more Divisions. They also set up the ability of a Division to extend a Rule Z notice to other Branches and Divisions, subject to their approval.37

There were isolated cases in which the running of Warning Notices went awry; in the first a Division Secretary inserted a Notice against the advice of his Chairman, and incurred the displeasure of his Branch. In another, in early 1908, the Chairman of a Division, who was involved in the dispute personally, wanted to remove an appointment from the Notice, but could not secure the agreement of his Hon. Secretary even to call a meeting. He had approached the Medical Secretary directly to see what could be done. This case resulted in the Council asking for a Conference of the Chairmen of the Committee concerned,38 which became the long-running Warning Notice sub-committee.39

However, as more and more problems came to light, including the Hampstead Hospital Dispute described below, the work of the WN s/c extended to over 2 years. In the meantime the Warning Notice was to have two minor legal challenges - both easily dealt with by the denial that it constituted a “black list”.40 When a member had enquired what the “force” of the Notice was, Smith Whittaker had replied that it was “simply ... a request from the Council ... to apply for information ... before accepting any appointment”. He added that expulsions in the past had never been for simply disregarding the notice - the member had always also violated the rules of the local profession or infringed medical propriety in some other way.41 This defensive and in some ways disingenuous reply demonstrated a growing sense that the Warning Notice was dangerous as well as useful.

“A most regrettable position”: The Hampstead Hospital Dispute 1905 - 1910

The Hampstead Hospital had been founded as “Hampstead Home Hospital and Nursing Institution” in 1882 by Dr Heath Strange, on Parliament Hill, and eventually became a 30 bed institution. From 1893 it admitted “free patients” and the paying patients were divided into two rates of pay. At this point the hospital shifted from being “open for any practitioner to attend his (paying) patients” to

37 Annual Report of Council, ARM 1907
38 MPC, 8.6.1910.
39 WN s/c, 22.4.1908. This initially consisted of the Chairmen of the Council, (Edmund Owen) M-pC (J A Macdonald), CEC (R Kinsey), Public Health Committee (C Watts Parkinson), and Hospital Committee (Frank Pope)
40 MPC, 8.6.1910.
41 CEC s/c, 27.3.1908.
having a "selected" GP staff. In 1903 it was decided to move to Haverstock Hill, and using £5000 from King Edward's Hospital Fund (KEHF) and an anonymous gift of £20,000 a 110 bed hospital was opened, whilst not yet complete, in 1905. The Hampstead doctors were not happy at this transformation. They felt that the hospital "was not required" in the district, and that "the selected staff of general practitioners" would obtain "undue advantage ... over their fellow practitioners". They demanded that changes be made to the proposals ensuring that the Casualty should send "unsuitable cases" back to their attending practitioner, and that all the local GPs should have access to the facilities and representation on the Board.

The King's Fund however, having paid in such a large donation, had great influence with the hospital board and would only offer the further support needed to complete the hospital if a staff of Consultants was appointed. In the spring of 1907 it was announced that the Hampstead Hospital was to merge with the North West London Hospital, but the local profession still hoped to influence the outcome. In May 1907 Hampstead Division resolved that there be no outpatient department in Hampstead, that GPs be allowed access to low paying and free beds, and be retained on the staff and represented in the management. Had this situation arisen 5 years previously it seems likely that the local doctors would simply have had to swallow their objections and make the best it. But they now had at their disposal a powerful set of rules and procedures for boycotting appointments. Thus in June, the Hampstead Division applied for a Warning Notice to be placed on appointments at the Hampstead Hospital, whilst the current staff of local practitioners all tendered their resignations.

The hospital Board turned for help to Sir Edmund Owen, Chair of the Council of the BMA, and for twenty years a visiting consultant to the Hampstead Hospital, who had just returned from a trip to Egypt. He was told that the Hampstead doctors intended to leave the Hospital without medical staff and accepted an appointment as consulting surgeon to the new hospital. Owen, along with the Presidents of the RCP and RCS then selected four men, Dr Sutherland, Dr Jackson Clarke, Sir John Broadbent and Mr Clayton Greene as consultants. All save Greene were members of the Marylebone Division of the BMA, but none had communicated with the Secretary of the Hampstead Division before accepting. However one consultant, Mr Knowsley Sibley, Chairman of Westminster Division, had heeded the Notice, and withdrawn his application on learning of the situation. Sibley wrote to the BMJ on March 9th 1908 saying he had done this "out of loyalty to the Council" only to find that "no less a personage than the Chairman of Council ... has himself

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42 Hampstead Div. meeting 10.11.1905, in BMAA B/63/2\1 pp.255 - 68.
43 ibid, pp.255 - 68.
44 Minutes of CEC, 1.11.1910 Owen to Chair CEC 19.10.1908.
accepted a post on the active staff and the advertisement has been altered accordingly. Comment is superfluous!” Alarmed, the Editor simply sent this letter to the CEC without publishing it.

The problem was referred back to the Marylebone Division, who soon applied to the CEC asking for advice not only on the specifics of the case, but about the history and ethics of the Notice generally. Robert Kinsey submitted a long memorandum on the case to date, which is most noteworthy for its exposition on the Warning Notice. Kinsey started his discussion with the statement that the Notice was not “as has been stated by some a ‘boycott’ or a ‘veto’ ... but a request ... to apply for information”, but went on to demonstrate that was just such a veto. His exegesis is a very clear example of the kind of thinking that underlay the BMA’s ethical work in many areas.

Kinsey pointed out that the Notice was intended to help practitioners “maintain the honour and interests of the medical profession” by providing “authoritative information”. It placed practitioners under two obligations, firstly

the general obligation of professional loyalty, to avoid, as far as possible, taking any action which may be detrimental to the honour and interests of the medical profession, and secondly, the obligation specifically affecting members of the BMA of complying with an official request of Council ... [which is for BMA members] ... beyond question. ... it is clearly the duty of a medical practitioner to take every reasonable precaution against placing himself in direct antagonism to his professional brethren in any district.'''

Turning to the “ethical authority of divisional opinion” he set out another apparent paradox. On the one hand “it is not intended to suggest that [practitioners] are absolutely bound by the opinion of the Division. The extent to which [it] must be regarded as binding will depend upon the circumstances of the case.” However, “if the Division have, in accordance with the Regulations of the Association, adopted rules which have the effect of prohibiting members from accepting particular appointments ... [they] must be obeyed.” And even if no rules had been broken “the opinion of the division must be taken into consideration by the practitioner himself ... and by the [Ethical Committee] when called upon to consider his conduct.” (It should be pointed out here that the gloss to the Bradford Rules published in 1905 stated that such resolutions were intended to be “binding”. Indeed in the 1910s and 1920s the BMA shorthand for these resolutions was “binding resolutions”.) Thus,

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45 Appendix 1, CEC, 19.5.1909.
46 ibid.
47 ibid.

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if a practitioner considered that the action of the Division in objecting to the acceptance of an appointment was not in conformity with the interests of the profession it would be his duty to apply to some higher authority in the Association, but meanwhile he should not take on himself the responsibility of rendering nugatory the action of the Division.48

If a doctor applied for information and ignored it “the propriety of his conduct would have to be considered in the light of the knowledge of which ... he was ... in possession”. A failure to apply, or to comply with the wishes of his fellows, would “create prima facie a presumption of an offence against the honour and interests of the profession generally ... and against the discipline of the Association”.49 In other words any member of the Association, and to a lesser extent any doctor, had an absolute duty to comply with the terms of the Notice, and the opinion of the local Division, and would have to justify any breach of this duty to the Division and the Association.

Only Owen and Broadbent answered their Division’s initial questions about their attitude and response to the Notice by explaining that they already knew all about the dispute, since Owen was already on the staff of the hospital, and that they could not leave the hospital without doctors. A meeting of Marylebone Division attended by heavyweights such as Lauriston Shaw, Charles Hawthorne and Victor Horsley found itself unable to decide the issue, and referred the matter back to the CEC.50

The CEC thus met with Broadbent, Clarke and Sutherland and reported to Council.51 Owen simply wrote to the committee saying,

the Hampstead Division have differences with th[e] Hospital and under their guidance the entire staff resign - without a word to me, their colleague. ... If I know the meaning of the word boycott, this was a boycott. ... When the hospital applied to me for help in their distress I should have counted myself something less than a man if I had declined. In my opinion the Division has been rash and unconstitutional ... I, a member of an honourable profession declined to be dictated to by the Division in their ill-considered attack.52

He admitted that he should have applied to the Division, but felt that they had “by their reckless action placed the whole Association in a most regrettable position”.

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48 ibid.
49 ibid.
50 memorandum, for ARM 1910, in CMAC SA BMA D183.
51 CEC, 20.10.1908.
52 Owen to Chair CEC, 19.10.1908, in ibid.
The CEC felt that Owen's actions and the subsequent "comment prejudicial to [the] value [of the Warning Notice]" threatened its "great utility ... in securing united action". Council recommended the resignation of all new staff, and set up a Board of Arbitration to negotiate changes necessary to allow BMA members to be on the staff. Owen resigned, but the other three remained in their posts. The Metropolitan Counties Branch Council called on these three "to express their regret and loyally assist in bringing about an amicable solution" in June 1909, but to no avail. Smith Whittaker wrote sternly to the three following discussion of the matter at the ARM, asking them to "close the ethical matter at issue" by expressing regret at non-compliance with the Warning Notice, but nothing happened. The CEC thus recommended to the Council that the three be expelled from the Association.

However, when the expulsion resolutions came before the Council in January 1910 they backed down. The minutes alluded to "the unusual and peculiar circumstances (which are never likely to be repeated)" and the fact that the three "apologised" for what they had done. In fact they scarcely apologised at all. They had written pointing out that the Warning Notice was "a request" to apply for information they already had. Furthermore whilst they had not acted "in a manner unworthy of a gentleman and a medical man", but that in order to settle the "lamentable dispute" they were now "expressing regret if the value of Warning Notices has been diminished with regard to such appointments as they are properly applicable to."

At the heart of this difficult dispute was a conflict between individual notions of honour and obligation and written rules that claimed to represent and embody these. The consultants involved in this case evidently felt that the rules had been abused, and that such disputes were none of their business. The rules had not been drafted to enable a group of GP's in one part of the Metropolis to prevent consultants in another from taking posts in a new hospital, simply because they resented being "cut out" of its new arrangements. But they still allowed the attempt to be made, and the ethical constructs underlying the rules placed these eminent doctors in a relationship of obligation to the general practitioners of Hampstead.

52 Council, 28.10.1908
54 BMA Archive B63/2/1 pp.93 - 4.
55 memorandum, for ARM 1910, in D183.
56 Council 26.1.1910
57 Council 26.1.1910
The Rules, the Notice and the threat of litigation

Initial changes to the Notice 1910 - 1914

The changes made to the Warning Notice regulations in the light of this and other disputes had the effect of taking some power out of the hands of the local Secretaries, and set up a whole supervisory system to make sure that disputes were being handled appropriately. The WN s/c decided that the Journal should carry advertisements for listed appointments, albeit with indications to their status. The CEC s/c was nominated to act as an “Emergency Committee” to consider disputes and applications for Notice continuations at short notice, whilst the CEC was put in overall charge of the Notices. There is no indication in the archive materials of the reasons why the CEC was chosen, but it seems likely that it was not only for the practical reason that the CEC or the s/c already met monthly.

Whilst the first Notice could, as before, be inserted at the request of a Hon. Secretary, it could not be repeated without the approval of the Divisional Executive Committee and the CEC, and would only be continued on receipt of monthly reports on the dispute in question. That the Association prized the Notice and felt it to be effective is further borne out by their response to Counsel’s opinion obtained on the Notice in the wake of the Mount Vernon Hospital Dispute in January 1914.

The Mount Vernon Hospital for Consumption and Diseases of the Chest had been set up in 1875, and operated on a number of sites in and around London: Northwood, Hampstead and Fitzroy Square. The Governors, led by the Marquis of Zetland, decided “for purely financial reasons” to rationalise this arrangement in 1912, by selling the Hampstead site; at the same time dismissing a number of junior medical staff on short term contracts. A meeting of the Marylebone Division on the 12th December 1913 decided to place any future appointments at the Hospital under a Warning Notice, and 12 out of 16 of the honorary staff resigned. The hospital Governors issued a writ against a number of members and officers of the Marylebone Division, essentially requesting that the boycott machinery be withdrawn and damages and costs paid. Their argument was that the Hon. Secretary and the BMA had “wrongfully, knowingly and without lawful excuse procured and induced many members of the Medical Staff of the Institution to break their legal contractual

58 WN s/c 18.3.1909
59 MPC 8.6.1910
60 Chancery Division, Writ issued 8.12.1913, in BMAA B/63/1/1.
relations with the Institution”. The matter was eventually settled out of court, and a statement placed in the *BMJ* to this effect.

However the Association decided to seek a legal opinion on the risk entailed in the Notice. Counsel was of opinion that,

A risk is incurred ... both of an action for libel and also of an action for ‘unjustifiable interference with contractual relations’ - a phrase which does not refer only to the violation of existing contracts but also to acts such as vocational or professional ostracism which prevent contracts from being concluded. ... if the notice merely meant that the Association gave information to professional men applying for an appointment, and nothing more, there would be no danger. Unfortunately it would be easy for a plaintiff to show that the notice means far more than this. ... it cannot be disputed that ... [it] constitutes what is practically a ‘black list’

The onus in a case would be on the Association to prove that accepting the post really was contrary to the honour and interests of the medical profession. Should they fail, “the Association and every person ... who took part in the publication of the notice would be liable to be sued.” This situation would be little altered if the plaintiff was a member of the Association. Even a simple resolution saying that an appointment was one that “no practitioner having the interests of his profession at heart should enter into it” would only be safe in the absence of any other rules, regulations or structures “to enforce the same, unless it is clear sufficient justification can be established”.

It is remarkable that the CEC decided to retain the Notice, rather than drop it altogether (as Hempson suggested they might) and did not even consider changing the other ethical rules. It may be that the modest changes they proposed were felt to be enough to ensure “sufficient justification”. It was decided that only the Executive Committee of a Division could submit an application, and the CEC was given absolute discretion as to whether to allow a notice, and the power to send any member of the central staff out to investigate a dispute.

**The Bedford libel case: 1908 - 1913.**

None of this helped avoid the first of two damaging libel cases arising out of the ethical rules and Warning Notice. The first involved an ethical problem that was to recur many times in the caseload

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61 Ibid.
62 CEC s/c 14.7.1914.
63 Gregory, Mr Holman, and Mr J Fischer Williams, ‘Joint Opinion on “Warning Notice”’, 28.1.1914 in D183.
64 CEC s/c, 25/3/1914
65 CEC, 5.6.1914
of the CEC.\textsuperscript{66} That was the position of a doctor who had got as far as seeing the accounts of a practice that he apparently intended buying or joining, who then decided not only not to buy in, but also to start independent practice in the area. Later ethical rulings condemned this practice, as did the medical men of Bedford when an incoming Dr Sloman offended their sense of propriety.\textsuperscript{67} Sloman had answered an advertisement placed by a Dr Clarke selling a practice that he claimed brought in £250 - 300 per annum in addition to £50 - 60 from contract practice. Sloman was interested but discovered on auditing the books that nearly a third of the income had come from one patient, now dead. He therefore broke off negotiations, but having already spent money moving his furniture down from Scotland, decided simply to set up from scratch in the town.

Dr Clarke approached the CEC in November 1907 complaining "of Sloman's ethical conduct in starting in opposition to him". Furthermore, since Sloman "had not paid [Clarke] the customary professional call" he could only settle things through a third party. (It was recommended in almost all ethical conduct texts of the period that on setting up a doctor should call on all his medical neighbours. De Styrap and Saundby both stated that it was this social ritual that entitled the doctor thereafter to his social status within the local profession.\textsuperscript{68}) The problem was referred back to the Division, and Sloman was summoned to a meeting in February 1908, and asked to explain his actions. He did not see that there was anything to explain, and the meeting resolved that "we are unanimously of the opinion that Dr Sloman unwisely offended against the recognised rules of the medical profession in immediately starting in practice in Bedford in close proximity to Dr Clarke."

Sloman offered to undertake either to buy the practice at a lower price agreed with an accountant, or not to see any of Dr Clarke's patients for a period of 3 years, but no agreement was reached. In October the Executive Committee of the Division resolved that

\begin{quote}
This committee is of opinion that Dr Sloman in coming to Bedford ostensibly to purchase a practice, and having obtained an insight into that practice, and negotiations having failed, the committee is still of opinion that Dr Sloman violates the rules of professional conduct by remaining in practice in Bedford.
\end{quote}

Nothing at all happened for the next four years. Dr Sloman continued to practice, and saw none of Dr Clarke's patients. However in March 1912 the Executive committee discussed the question of

\begin{footnotes}
\item[66] See especially, CEC 23.9.1924.
\item[67] unless indicated the information in this section is taken from the account of the court case, 'Action Against the British Medical Association', \textit{Br. med. J.}, 1913, B: 1119 - 23.
\end{footnotes}
meeting Sloman in consultation. (The rules of consultation issued in 1908 by the ARM stated that a doctor could refuse to meet another doctor of whose conduct the local profession disapproved. See chapter 7). In June they decided that the resolution of 4 years standing still held good and they applied to the CEC to circulate a notice under Rule Z, to ensure that all local men only met Sloman in an emergency. However, they had not actually adopted the Bradford Rules, and the CEC advised them that to circulate the notice was to invite litigation. Sloman, who up until that point had not realised that an incomplete boycott was in place against him, had written to them asking what the charge was, and had been told that there was none!

Despite the fact that no Rule Z notice had been issued, Sloman felt sufficiently aggrieved to sue for libel and slander. When the case was heard at Bedford Assizes in October 1913, the prosecution stated that the informal notices that had been circulated were libellous and that slanders had been uttered. The BMA, whilst admitting the facts, pleaded that the communications were privileged. Under the direction of the Judge it was agreed that Sloman would make a statement that the BMA had done good work, and that there had been no actual malice involved (a barely credible idea). He received in return an acknowledgement that the BMA had acted wrongly, the relevant resolutions were expunged from the minutes books, and he was paid £500 and costs. An added embarrassment was the fact that the then Chair of the CEC, Robert Kinsey was a member of Bedford Division, although he had no part in these events.

**The general Ethical Rules, up to 1915**

The 1914 ARM requested that the Council report “as to what steps can be taken to avoid incurring any financial loss for any libel action ... owing to the conduct of any Member, Division or Branch acting in opposition to the advice and instructions of the Council.” When the CEC s/c considered the problem they decided that the key was to induce Divisions to adopt the model ethical rules. Thus revised rules were proposed that stated that no ethical proceedings could be sanctioned for any Division or Branch that had not adopted them, and that all cases must be referred to the CEC first for advice. In any other situation the Association could refuse to take responsibility.

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69 CEC, 23.10.1914  
71 CEC s/c, 27.11.1914
The Model Rules in place in 1912 were largely the work of Langdon-Down. These 27 rules constituted a complete set of disciplinary procedures, including versions of the Bradford Rules. A précis of the functions and provisions of the rules is given below, for a simple Division. (There were three forms of the rules for different configurations of local units.) This précis is lengthy but has been given as the best way of demonstrating the basic design of the Association's local ethical machinery, and the principles underlying it. The Rules fell into two sections, the first, "resolutions as to professional conduct" dealt with the adoption and promulgation of resolutions on specific issues, the second described the investigation, judgement and punishment of practitioners in cases where a complaint had been made.

The 1912 Ethical Rules

Under these rules it was it was "deemed part of the business of the Division to consider questions of professional conduct". In order to make "resolutions as to professional conduct" the rules set out the procedure to be used to call a meeting or request a postal ballot of Division members on a resolution, and the circulation of the result to all members. These resolutions could set out general principles, or set up the duty of members not to accept certain appointments, or to behave in other specified ways. Rule 3 made it the "duty" of the Executive Committee to notify all members, especially new members and incoming practitioners of all important resolutions, whilst Rule 4 enabled a Division or Branch to bring a resolution to the notice of other local units. They could "request support", and, if in receipt of such a communication, communicate it to all their members. A last clause ensured that only general resolutions of the type discussed in Rule 2 were circulated in this way. It was the "duty" of the Hon. Sec. to "request" that members holding such posts mentioned in such resolutions either "terminate" or "modify" them (Rule 5).

Thus far the rules had dealt with resolutions of a meeting of the whole Division rather than a specific ethical inquiry. The much longer second section set out the "procedure of enquiry into professional conduct affecting individuals". Rule 6 enabled the appointment of the Division Chairman, the Hon. Secretary and 5 other members, or the Executive Committee, to "act as the Ethical Committee of the Division". This committee was to investigate complaints about conduct "in the first instance", of any practitioner living within their area. If the case affected a non-member "the matter shall be forthwith referred to the CEC for advice and instruction" which must be followed [original emphasis]. It was the "duty" of local officers to ensure that the person

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72 Council, 6.4.1936.
complained against had “personally, or by letter, or through ... intermediary” had “a reasonable opportunity of explanation”. On the other hand, a complainant’s failure to do this within a week would itself be “a matter for consideration”.

Meetings of the Ethical committee were to be called by the Hon. Sec within three weeks of receipt of complaint or instructions from outside the Division, or once preliminary enquiries were complete. If the practitioner complained against was a member of the Association they were to be notified of the complaint, to allow a chance to provide an explanation. (It is not clear why a non-member was not to be notified in this way). The Division could decide that it was “undesirable” to investigate locally, and they were “empowered” to refer to the Branch Council in such circumstances. (Rules 10 - 12) Any member, including the Chairman, who was “involved” or “interested” was to be replaced by another doctor on the committee. Procedure was not strictly stipulated beyond a statement that “the committee shall investigate the facts of the case and shall take such evidence, whether written or oral, as shall be deemed necessary”. However there was considerable emphasis on resolution, rather than adjudication, if possible. The function of these hearings was to contain and settle disputes without fuss, if possible, and it was therefore “the duty of the Committee, whenever possible, to bring the parties into personal conference in its presence”. The Chairman could apply for advice to the Medical Secretary.

If the parties involved could not come to an agreement, Rule 15 set out a series of possible ‘offences’ and ‘verdicts’ to be brought to a meeting of the Division. Three main kinds of ‘offence’ were set out. Firstly an offence against the “rules [or] resolutions of the Division [or] decisions of the Association”; or secondly an offence against “the generally accepted principles of professional conduct”; or thirdly of conduct “detrimental to the honour and interests of the medical profession [or] BMA”. For each ‘offence’ the committee could decide a number of ‘verdicts’: that there had been “no offence” and recommend “no action” be taken; or that “the complaint was frivolous” and the case “dismissed”; or that they had “no opinion” and thus referred the case on to the Branch or CEC. They could also find that that there had been a “violation” of ethical standards but that in “consideration of faults on the part of others concerned, the case be dismissed”, or that there had been a “violation” and the member censured. For the next two ‘verdicts’ the Division could also refer the practitioner to the Branch to consider “the propriety of their remaining a member” of the Association. The exception here was that expulsion could not be requested if the ‘offence’ was of the vaguer kind - against “the generally accepted principles of professional conduct”. A non-

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73 ‘Rules Governing Procedure in Ethical Matters of a Division not itself a Branch. Approved by the Representative Body, July 1912’, Br. med. J., 1912, II: supplement, pp. 231 - 3
member could be found to have “violated” rules or the honour and interest of the profession, but be allowed a period of time to “consider his position”. A last option related only to members, and allowed no “time to consider”, and expulsion to be sought without further ado.

Following this the rules stipulated that the Division should meet to ratify the Ethical Committee’s decision, and that the Report of the Ethical Committee should reach each Division member 7 days before the meeting. At these meetings members of the Ethical Committee were allowed to take full part in discussion and voting. (Rule 25, however, made it the responsibility of those with membership of ethical committees and other bodies at different levels in the Association to decide at which stage they would adjudicate on a case, stipulating that they could not do so twice.) These meetings could not discuss or dispute the “facts” of the case. The options for the Division were to accept the Report and Resolution, amend the Resolution, but only to another one of those listed in Rule 15, or refer the case back for consideration. Once adopted or amended this resolution was to be circulated to all parties who were members of the BMA.

Rule 20 allowed such a meeting to withdraw “censure under Rule 15 (v)” (that is where expulsion was not being considered) if the practitioner “shall make amends, or express regret to the satisfaction of the Division”. Once made, the findings of the Division were final unless new facts justified re-opening the case. That said, if a practitioner felt “aggrieved” by the findings, Rule 22 allowed an appeal within fourteen days first to the Branch, thence to the CEC, and finally to Council. If an appeal was lodged “no action shall be taken to give effect to the finding appealed against, pending ... the appeal”. Under this system, once a problem was submitted to Association ethical adjudication no appeal to another professional body was allowed, but this would have bound only members of the Association. Furthermore all members were bound to assist in these matters, not just generally, but by providing up to 10 copies of relevant documents if requested.

Rule 26 was another long rule; essentially a re-working of several of the Bradford Rules. It stated that “no member of the Division shall meet in consultation or accord any professional recognition” to a practitioner subject to the last two most stringent ‘verdicts’ for offences involving breach of rules or resolutions, or conduct “detrimental to the honour and interests of the medical profession”. There were 4 provisos. First that no interference with the functions of Public Officials be included, second that “in circumstances of great urgency, affecting the life of a patient” the practitioner could be met. However, such a meeting or recognition would have to be explained to the Hon. Sec and the Ethical Committee. Thirdly if the practitioner was exercising the right of appeal, and fourthly
"if the Division shall ... declare ... by a resolution” that the conduct of the doctor was no longer offensive.

Rule “Z” remained and allowed that where the Division had passed a resolution under Rule 15 of the type that could warrant expulsion, a report was to be sent to the CEC; and subject to their approval, a notice was to be circulated to every member of the Division. Such notices were to be sent out in a sealed envelope and marked ‘private and confidential’.

Several points can be drawn out from these rules. Firstly a considerable amount of close reading is necessary to understand them, and it is, therefore, not surprising that local Divisions sometimes misapplied them. That said, whilst these rules carefully guided the actions and procedure of local members, they did not question the basic competence of such groups to adjudicate matters of professional conduct. Neither was this basic feature to change. This was most remarkable in the absence of any fixed code or comprehensive set of rules of conduct (as opposed to procedure), and is reflected in the openness of the offences against “generally accepted standards” and “the honour and interests” of profession and Association. That said, the rules tried to allow for conflict resolution to occur as well as condemnation or acquittal. Perhaps the most striking feature was that although they referred to the “duties” of members of the BMA, the way they were constructed meant that a non-member could be affected by them. Indeed non-members appear to have had no right of appeal within the BMA at all; the only thing they were spared was expulsion from the Association.

Changes considered and adopted for 1915

The two main changes proposed in 1914 following the Bedford Case, were to prevent any ethical investigation to take place without the prior advice of the CEC, and to make the CEC the “final court of appeal”. The final result of this revision was that the Rules were lengthened to 29. The CEC was no longer to be informed of general resolutions (1912 rule 2), presumably since they were to be more closely involved elsewhere. The notification of non-members about general resolutions was now specifically provided for. Members were simply ‘told’ and expected to resign or modify their appointment, whereas the Division was to “suggest” to non-members “the propriety” of either resigning from or modifying the post. (Rule 5) A new rule set out that a complaint about conduct had to be made in writing, and the CEC had to be consulted before any further action was taken. To emphasise this a “NOTE” was added, saying “The Association will

74 CEC s/c, 27.11.1914.
75 The revision sheets and final versions can be found in, CMAC SA BMA D203.
accept no responsibility whatever in connection with any ethical matters not so referred or when the advice and instructions received from the Head Office are not carried out, or in connection with which any action has been taken except under such advice and instructions”.

An upper limit of 9 members in total was set for an Ethical Committee (1915 rule 9) and a new rule stated that “all parties to a dispute shall be invited” to the meeting to consider the Committee’s report and recommendation (1912 rule 16). An important new rule set out that the only grounds on which an appeal could be lodged were either “that an ethical principle has been wrongly interpreted or applied, or that the decision is given against the weight of the evidence”. This change was designed to be analogous to the grounds of appeal in Civil Courts.\(^7\) This rule envisaged the possibility that a Division could be held to have applied an “ethical principle” incorrectly despite the fact that no set of principles existed in an generally endorsed textual form. It was also decided that to safeguard against the waste of Council time in needless appeals, a deposit would be requested if the case came to the CEC on appeal to offset the cost of a Council hearing.\(^7\) The ARM was “urged” by Council to adopt the new rules without modification and in substitution for all existing rules, and to accept that no other rules would be recognised after December 31st 1915.

It is doubtful that this revision would have safeguarded the Association from legal risk, but as events were to show, the CEC had closed the stable door on a horse that had bolted several years earlier. A long-running dispute in Coventry culminated in a libel action being brought in January 1915, just as the new rules were being finalised by the CEC.

“Prolonged, Deliberate and Pitiless”: The Coventry Dispute, 1906 - 1918

I recount the story of this dispute in detail for three reasons. It is the only instance I know of where the details of an “ethical” dispute over appointments came out under oath. The case demonstrated, indeed it turned on, the ruthlessness with which the boycott scheme was operated by local BMA members. The case demonstrated that in several instances rigid adherence to a set of resolutions couched in terms of “honour”, that clearly served the Divisions “interests”, allowed doctors to override ordinary standards of morality, and at one point, even the injunctions of the GMC. Lastly it is important that the ghastliness of the behaviour of the Coventry Division, and the adverse public

\(^{76}\) CEC s/c 8.1.1915.

\(^{77}\) ibid. The CEC and Council were keen to avoid Council hearing for reasons of expense, time, and cross-membership of the Council and CEC.
opinion of the case be understood, if only to contrast it with the modest response of the Association and the CEC.

The Coventry Provident Dispensary was founded in 1831. In 1906, when the dispute began in earnest, it had 20,000 subscribers paying 4s. per annum. It employed 7 doctors who each received roughly £300 per annum for their work, which took only part of their time. The Dispensary was run by a committee consisting of 24 laymen elected at an AGM, a secretary and the Dispensary’s medical officers. These doctors, along with the vast majority of the city’s medical men were members of the Coventry Division of the BMA. Discontent had been rumbling on inconclusively at the Dispensary since the 1890s, and whilst the Dispensary had agreed to stop canvassing for subscribers in 1905, after the publication of the GMC Warning Notice, other demands had not been met.

The Formal Dispute

In February 1906 the Coventry Division had adopted not only the Bradford Rules, but also principles and rules by which they wished the Dispensary to be run, based on those suggested by the MPC Contract Practice report of 1905. A meeting on 3rd April resolved by a majority of 21:1 that “no member of the profession in the area of the Division should associate himself with ... any provident dispensary ... managed” along different lines. They demanded that the Dispensary subscription collector be paid by salary and not on commission; that the committee of management consist of the medical staff and an equal number of laymen; and that there be a subscriber wage limit of £2 per week. This latter would promote private practice, as would the resolution that dispensary work to should be open to all local doctors who had bought into practice in the city. Whilst the Dispensary management agreed to change the method of paying the collector, they felt that cases of abuse by the well-to-do were rare, and declined any further reforms.

Five out of the seven dispensary doctors resigned in spring of 1907, following a meeting of the Dispensary Staff, the Executive Committee of the Division, and Alfred Cox, who was present to give advice on how to proceed, in December 1906. The Coventry doctors were worried that if they condemned all doctors working for the Dispensary one very old staff member, Dr Cairns, who was too old to find other work and too poor to retire completely, would suffer. Cox advised them that

78 unless otherwise stated, all information in this section is taken from the judgment of Justice McCardie, published in full in, Br. med. J., 1918, ii: Supplement 26.10.18, pp. 53 - 60.
79 See note 32. above.
80 Coventry Division, 3.4.1906, in CMAC, SA BMA D133.
they could only support the Dispensary staff by passing a resolution condemning the appointments outright. They were also concerned not to lose their Dispensary patients. One option was to set up a rival dispensary, and to merge with the Coventry Public Medical Service once the Provident Dispensary had been "squeezed out". Cox felt that despite "objections on grounds of principle" this scheme had "very important practical advantages." The meeting also wanted to know whether ostracism could be continued after a man had resigned, or the Dispensary reformed. Cox left this entirely up to the Division to decide.\(^8\)

Having resigned, but whilst still working for the Dispensary, the 5 doctors canvassed their patients to join their "New Dispensary" and succeeded in securing 7,000 subscriptions making it "an immediate pecuniary success". Meanwhile, despite listing in the \textit{BMJ} Warning Notice, the Provident Dispensary recruited three more doctors, Burke, Ellis and Langley.\(^2\) On being appointed all three received letters from the Secretary of the Division stating that a boycott would be applied if they continued in their posts. On the 20th of August, the Division decided formally to ostracise the three. Notices under Rule Z were circulated to all members of the Division and the next month the expulsion of Burke, Ellis and Langley from the BMA was requested.\(^3\)

One irony of this story not mentioned in the trial was that the resigning doctors had, in their efforts to make the new Dispensary a success, breached the GMC’s injunction against canvassing, which they had previously used to object to the Provident Dispensary’s arrangements. Burke, Ellis and Langley brought a case before the GMC in November 1907 in which Drs Arch, Fenton, Hird and Pickup, were found "guilty of infamous conduct in a professional respect" for having "joined ... in forming, and are [on] the medical staff of a dispensary ... which systematically canvasses for patients".\(^4\) Surprisingly, none was struck off, and it is tempting to suppose that their role in the contract practice boycott secured them this immunity. This was the only blow the boycotted men managed to strike for another 8 years.

\(^{81}\) Appendix A, MPC, 9.1.1907
\(^{82}\) Burke was not listed in the \textit{Medical Directory}. Alfred Pytches Blanchard Ellis, trained in Glasgow and St. Mary’s Hospital London and qualified LSA in 1898 and LMSSA London in 1908. He had been a Civil Surgeon in South African Field Force, and served as Plague MO in Amritsar, Gardarpur and Hissar. Once in Coventry he also worked for the Public Medical Service there. (\textit{Medical Directory}, 1913.) John Inman Langley trained at St Thomas’ Hospital London, and qualified MD (Brussels) and MRCS LRCP in 1898. (ibid.)
\(^{83}\) CEC 4.12.1907, Council 29.1.1908.
\(^{84}\) GMC, \textit{Minutes}, XLIV, 1907, pp. 122 - 124
The boycott was extended by issuing Rule Z notices to the Divisions and Branches of Birmingham, Nuneaton, Tamworth, Leicester, Northampton, Nottingham, Leamington and Warwick, and York. Writing to these Divisions the Coventry doctors stated “we are having a great fight here in Coventry, and wish to strain every nerve to make the position of these men as unpleasant as possible”. The ostracism was social as well as professional, “the doctors and their families were ignored at all times and on every occasion, and were deliberately treated as ... outcasts”. The Coventry men also managed to include nurses and dentists in the scheme, by threatening to find staff elsewhere, and by threatening to withdraw goodwill respectively. On the few occasions that other doctors did meet with the Dispensary men, they were summoned before local ethical committees to explain their actions, even if the patient over whom they were consulted was obviously *in extremis*. On one occasion Dr Burke was ejected from the Warwick and Coventry Hospital where he was visiting a patient.

By 1912 Ellis and Langley decided to leave and their posts were taken by Drs Pratt and Holmes. These two men were subjected to the same treatment as their predecessors, culminating in the extension of the boycott to Staffordshire in its entirety, and the expulsion of Dr Pratt from the BMA. Pratt’s experiences of Coventry etiquette began with a visit from a Dr Kennerdine in May 1912. “If you take the position”, Kennerdine told him,

> you will be boycotted, and your life and the life of your wife and family will be made miserable. Even if you take the post for three months, you will not only be boycotted for that three months, but if you go to any other town you will be boycotted there, and it you go to the ends of the earth still the BMA is everywhere and they will find you. Even [in] Australia or South Africa you will find the BMA

This same Dr. Kennerdine was involved in an incident in which he refused to attend a dying woman until her husband wrote a formal renunciation of Dr Holmes and the Dispensary. Kennerdine stood over the patient’s bed while he wrote a letter confirming the renunciation of the boycotted doctors, during which time his wife actually died upstairs. Such refusal was not unusual: several other Coventry doctors had also refused to treat patients of the ostracised doctors.

The dispute had acquired a momentum of its own, as became clear when Pratt was summoned by the CEC prior to his expulsion. It was suggested to him that the Dispensary doctors were “sweated”, to which he replied, “How are they sweated? I finish my work, as a rule, at one o’clock

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85 Ernest Camden Pratt trained in Birmingham and his *Medical Directory* entry reveals only that he qualified LSA in 1902 and that he was Medical Referee for the Royal Star Assurance Co. No entry appears for Holmes.

86 Council, 2.7.1913.
each day apart from two evenings a week. I have ample time for my leisure. My remuneration, moreover, works out at over £600 a year. In what way are we sweated?”

However, the final insult which triggered the legal action against the Association was an article on contract practice in the Supplement to the BMJ in 1914. This article stated that, “the medical officers secured for these posts” were either “the failures of the profession”, lacking the “initiative to make a success of private practice”, unfortunates who “through financial loss or too early marriage” had to secure a salary, or junior doctors who applied “unwittingly”.

This was a clear libel and a statement of claim was filed by Pratt, Burke, Holmes and Cairns against the BMA, and Drs Lowman, Pickup, Orton and Webb-Fowler in January 1915. In this statement almost every action of the BMA against them that used the phrase “guilty of conduct detrimental to the honour and interests of the profession” was accounted a libel, or when spoken as a slander, including the motions expelling them from the Association.

Judgement

After 3 and a half years of resistance and delay, during which time Dr Cairns (the old doctor whose wellbeing Cox had advised should not come into consideration) had died, it was eventually agreed that the case should be heard, under special arrangement before a judge without a jury. The judge, Mr Justice McCardie, had only just been appointed, and held unusually liberal views. He was involved in several cases that have a bearing on this thesis, and indeed he had, as a barrister, acted for the Dispensary men in bringing the 4 boycotters before the GMC. The hearing took 2 whole weeks, in July 1918, with evidence being given by all the plaintiffs and defendants and by patients of the ostracised doctors. Also giving evidence for the BMA were Alfred Cox, and James Neal. Having heard the evidence, the hardworking McCardie took three months to decide the full substance of his judgement, which involved complex application of legal principle and precedent. On 15th October he spent four hours reading his judgement, which set important precedents in Trades Union and contractual law. He found the BMA and the individual defendants guilty of libel, slander and conspiracy, on the basis that the BMA and the Coventry doctors had acted with actual malice, and without just cause. His verdict rested on “the duty and power of the Courts to protect a man in the lawful exercise of his calling.” In summary he stated,

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87 Two thorough searches of the supplement for 1914 have failed to locate this article, but its existence cannot be in doubt - it was one of the main points in the prosecution case.

88 A biography of McCardie appears on p. 338.

Upon the words "to maintain the honour and interests of the medical profession" has been erected a powerful scheme and machinery throughout and beyond the United Kingdom ... [the aim of which] ... it is admitted ... is to inflict professional ruin on any medical man who breaks a rule of the local body, or the head body. This grave power is used against those who ... have never belonged to it. [Any medical man] may be exposed to degradation and dishonour at the will of a body which is devoid of the slightest statutory sanction on that behalf.

The BMA were ordered to pay a total of £3,810 to Drs Holmes, Burke and Pratt.

Responses to the Coventry Case

In the wake of this judgement there was a rash of bad press for the BMA. Even Lancet's editorial broke its neutral tone in the last sentence, saying the "verdict had been very widely anticipated". ⁹⁰ Local newspapers spoke of the "the undoubted agreement that most people w[ould] feel with the [comments of the judge]", ⁹¹ and noted that "the whole dispute has been an unedifying and a most unpleasant one. ... The question of ethics, medical or otherwise had nothing to do with the case." ⁹² Another commented that it was "evident that sometimes the BMA oversteps the borderline between self-defence and tyranny". ⁹³

The national press also took an interest in the case and found many doctors willing to comment adversely on the Association. For example a "London GP" was interviewed under the headline,

**DOCTORS CONDEMN THEIR UNION**

**BMA controlled by a clique**

**MANY IN REVOLT**

He said,

Exactly the same spirit of tyranny was shown by the same class of men when the Insurance Act was introduced. Doctors were threatened with ostracism if they went on the Panel to perform their national duty. One of these men has never spoken to me since ... Such methods of tyranny defeat themselves ... men who tried to frighten us from the panel are today almost without patients while I for one am making £2000 per annum." ⁹⁴

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⁹¹ *Coventry Herald*, 19.10.18, in D133.
⁹² *Midlands Daily Telegraph*, 16.10.18, in D133.
⁹³ *Manchester Guardian*, 17.10.18, in ibid.
⁹⁴ *Daily Express*, 17.10.1918, in ibid.
The BMA found itself styled "A BAD TRADE UNION" accused of "ruthless selfish particularism". Alfred Cox was accused of "supercilious intolerance" in an open letter in *John Bull*. The *Westminster Gazette*, in an even handed piece, thought the BMA had "acted with little discretion ... the local doctors had a thoroughly bad case and the[BMA's] influence ... was exercised wholly in the wrong direction."  

There were no further actions against the BMA however, and it seems that this case, for all its impact on the Association, was perhaps, an extreme example of what could occur under the Boycott scheme rules. Other changes, chiefly the introduction of National Insurance and the Wartime draft of large numbers of doctors out of civilian practice may well have reduced the likelihood of any further litigants coming forward. There were also the significant changes that had been made to the Rules by this time.

In the immediate aftermath Cox considered that the judgement had "deprived" them of "rights prized by the Association". If even advice to members over contract practice issues could be actionable, and any method of "exhibiting a personal sense of disapproval" construed as a threat, the Association might be reduced simply to bringing cases before the GMC. The worst blow was the verdict that the "Important Notice" was libellous, since it was by far "the most useful weapon" the Association possessed. Yet despite all that had occurred, he argued for its preservation in "as near its present form and position as possible." The option of making the BMA a trade union was rejected on the grounds that it would not guarantee immunity from prosecution. The bad publicity, whilst carefully filed with memoranda and minutes, was not apparently a factor in Cox's thinking, and did not appear in the deliberations of the special "Committee on the Position arising out of the Coventry Case". This committee was initially undecided as to whether to keep the rules allowing a Division to forbid doctors to meet another doctor, and the rule allowing the circulation of "rule Z" notices. Within a fortnight they had stiffened their resolve, and decided to keep the rules.

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95 *Idem*, 18.10.1918, ibid.
96 *John Bull*, 25.10.18, in ibid.
97 *Westminster Gazette* 16.10.18, in, ibid.
98 Cox, memorandum, in D133.
99 Its members were James Macdonald, Moses Biggs, (Sir) Henry Brackenbury, Garstang, G E Haslip, E B Turner, T Jenner Verrall, and William Hempson the Solicitor.
100 Coventry case sub-committee, 14.3.1919.
101 Coventry Case sub-committee, 28.3.1919.
The Rules and Notice after Coventry

The preamble to the 1919 rules disclaimed any responsibility for any actions taken by Divisions which did not follow the rules to the letter. Local officers were informed that “any doctor or body of doctors [had] the right to decline to meet any other doctor professionally, this being one of the common rights of citizenship”, but warned “it is wise not to specify any reason for such action, even verbally, ... and certainly not in writing ... unless advised by the Head Office.” Practitioners could be invited to meet representatives of a Division about an appointment, and without threat, informed of the objections of local doctors, and their likely disinclination to meet with any appointee.  

The rule on ostracism was redrafted to say it was “undesirable that a member of the Division should meet in consultation or [recognise]” the ostracised doctor, where the 1915 rules had said that “no member ... shall ... meet ...”  

The rule no longer specified that any meeting or recognition would be investigated so that no penalty was now stated to be attached to breaking the boycott. The Rule Z notices were retained, (with directions that specified that they be sealed, and marked “for the use of Members of [the] Division only”), along with the Important Notice in the Journal. Despite this apparent return to “business as usual” the Coventry libel action prevented the Association pursuing high profile ethical offenders on at least two occasions in the 1920s, as we shall see in Chapter 9. Cox urged the CEC “to be ever cautious [rather] than to run any risk of involving the Association in a law case”. It seems this caution was shared by the Divisions, since no applications were received for Rule Z notices between 1918 and 1923, and in 1935 they were noted to be “infrequent” except in the perennially disputatious South Wales colliery areas.  

The shift to Public Health appointments

A great deal had changed in the world of British medicine, and in the country as a whole, since the boycott machinery was devised. After a vitriolic struggle in 1911 and 1912 Lloyd George had succeeded in passing his National Insurance Act which effectively placed contract practice under the control of Government. The Friendly Societies were now controlled in their provision of health

102 Memorandum of Instruction, CEC, 11.5.1920. 
103 Revised Rules, document in CMAC SA BMA D 203. 
104 The rules were published in Br. med. J., 1919, i; Supplement, pp. 106 - 8. 
105 Cox, letter, 24.8.1919, CEC s/c, 2.9.1919. 
106 Memorandum, CEC s/c 11.5.1923. 
108 The biography section instances several BMA careers in which this was a watershed.
care by the Insurance Commissioners and local Insurance Committees, on which the medical profession was well represented. Bargaining over pay was centralised and carried out by the BMA’s Insurance Acts Committee. The profession had also managed to secure what was in effect a 100% capitation pay rise, despite evidence that in private practice doctors were earning just as little as they were in contract practice. What was more the principle of “free choice of doctor” (that is, the free choice of doctor by patient) - a deeply entrenched article of faith throughout this period - had been enshrined in the Panel practice system.

Although some in the Association wanted to use the ethical rules and machinery to ensure rates of pay in salaried public posts, these changes partly explain why, despite the urgings of Council and ARM, the Divisions were slow to adopt the 1919 rules.

It has not been possible to discover whether these Divisions preferred older stiffer sets of rules, or whether they disdained the whole boycott machinery, or whether they were simply apathetic. After this most prolonged and concerted effort to get a model set of rules adopted throughout the United Kingdom the CEC vigorously resisted any further changes to them.

Table 10: the adoption by Divisions and Branches of the revised ethical rules 1919

<table>
<thead>
<tr>
<th>Year</th>
<th>Divisions without new rules</th>
<th>Branches without new rules</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>number</td>
<td>%</td>
</tr>
<tr>
<td>1919</td>
<td>-</td>
<td>100%</td>
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<tr>
<td>1921</td>
<td>65</td>
<td>46%</td>
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<td>1923</td>
<td>45</td>
<td>32%</td>
</tr>
<tr>
<td>1927</td>
<td>12</td>
<td>9%</td>
</tr>
</tbody>
</table>

The Notice is “automated” and audited, 1920 - 1926

Remuneration in the burgeoning public health sector was of interest to the BMA of course. Local authorities offered widely varying salaries, expenses and allowances. The rapidly rising cost of living after the Great War resulted in great difficulty for Divisions and the Association in deciding whether a post was indeed underpaid, and a scale of pay for public health posts was ratified by the

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110 CEC 23.9.1923.
ARM in 1923. During the preparation of this scale, in 1921, the CEC added a third method of submission for the Important Notice. The CEC chairman could insert one “where an advertisement for a medical appointment is offered on terms and conditions which are contrary to the decisions of or policy laid down by the [ARM] or by the Council”. The use of Notices on salaried posts by Divisions had “on several occasions ... had the desired result”. However, no Notices were accepted from Divisions without the new Rules. Indeed the need to place such notices by Divisions was “one of our chief levers in bringing pressure to bear on a Division to adopt the Ethical Rules of Procedure”.

The CEC made the insertion of notices easier in other respects, chiefly by making the approval of the Chairman automatic under a “standing order”. Since the posts were advertised in the BMJ the secretariat were the first to know, and it was felt to be “the duty of the Committee and the office” to issue these notices without the “unnecessary” delay cause by Divisional applications. In these “automatic” notices, the committee were to disregard the non-adoption of rules by Divisions, to avoid inadvertently “punishing” applicants from outside the area.

A quite profound shift had occured in the relationship between local and central groups. The Divisions were no longer left to manage their own affairs, those without the rules that stipulated close supervision were not allowed to request notices, or, in effect, to run formal disputes. On the other hand the Association now by-passed the Divisions and automatically placed Notices on posts falling outside criteria adopted by the ARM. These automatic Notices constituted the vast majority. In June to December 1923 notices had been placed on 12 contract practice posts (7 in Wales and another 3 in colliery areas), whilst 19 notices were placed on public health posts. In January to April 1924 only 1 new contract practice notice was requested, but 31 notices were placed on public appointments. However the system appeared not to work well. No statistics were given, but “the committee found that numerous appointments ... ha[d] been filled at a salary below the minimum set by the ARM 1923, and that in a number of these cases the Division or Branch has taken no action in the matter.” Although there is no way of checking its effectiveness independently at any

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112 CEC, 1.4.1921.
113 Annual Report of Council 30.4.1921.
114 Memorandum, CEC 9.1.1922.
115 CEC 26.9.1922.
116 Council 25.10.1922.
117 Report, CEC 12.1.1924.
118 Report, CEC, 13.5.1924.
119 Council Agenda 11.6.1924.
point, the "uncoupling" of the Notice from local interest in it appeared to be damaging its
effectiveness.

This is not to say that public appointments made below the agreed scale did not excite high feelings
in some Divisions. One example serves to illustrate this very well. In 1924 the CEC considered a
proposal from L A Parry of Brighton Division that would allow a Division, after consulting the
CEC, to send the appointed doctor a letter of censure, without requesting that the post be improved
in any way. The CEC, of which Parry was of course a member, styled this a dangerous "short
circuit" of the system. Parry explained,

> We think ... that the request for action [that is, to secure the appropriate salary or resign] ...
> may actually lead to this practitioner, who has violated the rules and regulations of the
> Association, obtaining assistance to get an increased salary or improved [conditions] ... it
> appears to us that loyal members who have refrained from applying ... are at a disadvantage
> compared with disloyal members of the profession.°°

Another letter revealed that there was a gender issue involved. Many of these public health posts
were taken by women (especially the lower paid ones) and these women were thus doubly
'transgressive'. There was no point, said Parry in another letter, simply calling "the attention of the
'blackleg' practitioner to the matter, and suggest[ing] to her how she may obtain better terms at the
expense of her loyal colleagues." Brighton Division wanted to make these doctors uncomfortable
rather than help them.

The CEC had concluded that this manoeuvre required a complete disruption of the Associations
rules and constitution,°° and thus it is not surprising that Langdon-Down and Hempson spoke
passionately against the motion calling for the change at the ARM of 1925. Describing the Ethical
Rules as "the one nightmare in his life",°° Hempson pointed out that the Division should make sure
a resolution against the post was adopted before anyone applied, and that their failure to do so was a
reflection of the autonomy they were given.°° It seems however that many outside the circle of
aficionados who had devised and revised the rules simply did not understand them. This impression
is strengthened by the subsequent changes to the appointments system. It was suggested to

°° Agenda, Council, 22.10.1924.
°°° L A Parry, letter, CEC, 3.11.1924.
°°°° L A Parry, letter, in CMAC SA BMA D204.
°°°°°° a sentiment with which the author concurs.
divisions in 1931 that they pass resolutions that automatically disgraced any practitioner who took a post at a salary below the agreed national scale. But despite frequent reminders and cajolings many Divisions failed to undertake this simple manoeuvre.\textsuperscript{126}

\textbf{Discussion}

This, the earliest, most complex and prolonged codificatory activity the CEC undertook was intimately bound up in a scheme that shared many of the features of trades unionism whilst deploying, to great effect, the language of honour. Ideas of medical solidarity, and of duty to the profession and the Association, were used to construe doctors who broke ranks with their “professional brethren” as guilty of conduct “contrary to the honour and interests of the medical profession”. In the story of the BMA’s effort to raise and maintain the pay and status of its employed members, ethics and politics, honour and interests, cannot be separated. This is particularly demonstrated by the way in which the rules put in place to deal with unprofessional conduct generally were set within a framework that envisaged their use to enforce solidarity in ostracising doctors who took disputed appointments. In this respect local groups of doctors were initially given great autonomy, and even when the more formal structures relating to appointments became increasingly centralised and automatic, the Divisions were still left with rules that allowed them to investigate cases of alleged misconduct or settle disputes between colleagues. As I have pointed out, procedure was defined, but not the actual “ethical standards” themselves.

It is impossible to read the minds of those who decided to retain this scheme in the face of mounting legal criticism, and they left no evidence to indicate whether it was the ideal of honourable solidarity or the immediate pecuniary success that was most important to them. The available evidence would tend to suggest that these two would be regarded as inevitably interlinked in a manner analogous to the blending of Divine and Secular authority in the minds of men prior to the Renaissance.

In the treatment of those who did not fall in with local opinion, cruelty, spitefulness and tyranny - at times extended to patients themselves - was justified by the language of honour. The treatment of “blacklegs” is striking, particularly when set against the deliberately conciliatory stage specified in the handling of complaints against one practitioner by another. The “blacklegs” had already, in this system, set themselves apart from the gentlemanly world of conciliatory settlement. Whilst this polarised view was evident, particularly in the Edwardian years, the scheme either existed under a

\textsuperscript{126} CEC 1.10.1935.
dense layer of linguistic camouflage, or was construed with particularly Jesuitical complexity. The individuals in Bedford, Coventry, Hampstead, or in any of the Divisions that failed to use the system correctly, do not appear to have been criticised as being at personal fault. The BMA defended the system despite the evidence that many within it were untrustworthy. Whilst these rules dealt with behaviour and allowed judgements on conduct to be made either in advance or after the event, they were also predicated on a deeply held, almost instinctive idea of the professional group.
Chapter 7

The Ethics of Consultation

Introduction

Calling in another doctor as a consultant was a central consideration of medical ethics in the nineteenth century, and one of the reasons for this is easily stated. Medical practitioners of all sorts were reliant on the help and advice of more expert or experienced doctors to deal with difficult cases. However since the incoming, senior practitioners could easily supercede the attending practitioner, either at the invitation of the patient or her friends, or through deliberate manoeuvring, the doctor in attendance had to balance two risks. He could risk losing the patient for want of advice or assistance, and further patients through loss of reputation, or risk losing the patient to the other doctor, and with her further patients.\(^1\) The place of consultation ethics in Percival’s *Medical ethics*, and its derivatives was the grounds for the charge that these works were simply codifications of etiquette rather than ethics proper.

It is unsurprising that the BMA should have turned its attention to codifying the proper conduct of consultation. There is however little evidence in the archival materials examined of a particular crisis within the profession on the issue in the mid-1900s. It seems to have been, rather like the contract practice issue, a long-term grumbling problem, which the BMA was in a position to solve in a new kind of way. For instance, Muirhead Little says (characteristically without saying why) that consultation had “for some years caused discussion and sometimes bitterness in the profession”.\(^2\) Drafting these rules was the second large task undertaken by the CEC, and although they produced detailed rules, these were clearly based on previous codes and were presented as an expression of “best traditions” of medical behaviour. At the same time, the CEC reworked these “traditional” ideas within an organisation that aimed to unite and represent all kinds of doctors, and the committee had to draft their rules in dialogue with the Council and ARM. The resulting conception of the relationships between doctors was to form a central part of the BMA’s work in the interwar years, and was applied to situations quite different from those originally envisaged.

\(^1\) Patients were often referred to as female, particularly by Saundby.


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I have introduced an artificial split in the subject of consultation and relationships between practitioners. Although the discussion of the question of consulting with medical homeopaths was often linked to that of consultation between ordinary doctors, the aspects of consultation ethics relating to associations with unqualified or unorthodox practitioners are held over for the next chapter. However a little discussed and seldom ‘visible’ aspect of the relationship between doctors, the splitting of fees, otherwise known as dichotomy, is discussed at the end of this chapter. It represents a quite different pressure on the supposedly disinterested decision to call in the best available advice or expertise; that of collusion and corruption.

**Codifications of consultation ethics prior to 1908**

**Percival’s Medical Ethics**

Percival’s code discussed ideal consultations in two contexts, hospital medicine and private general practice. In the former he dealt with the situation in which a large number of practitioners of different disciplines saw a patient together on the wards. He stressed “harmonious discourse”, but was at pains to keep “the two professions” of physic and surgery separate, except on “cases of a compound nature”.^1 Order of precedence and seniority were the main bones of contention in Percival’s experience, along with the settlement of differences of opinion, and he set out strict guidelines to clarify seniority and the casting vote in case of disagreement.\(^2\)

In general or private practice he dealt first with the situation in which the patient or their family sought an second opinion for themselves. The new doctor should not consider it beneath him to consult with the previous one, since this would provide important information and prevent bad feeling.\(^3\) He also stressed the importance of consultation between doctors in difficult or protracted cases for the “confidence, energy and more enlarged views in practice” they could bring. In private practice, in contrast to hospital protocol, the attending practitioner was to introduce the case, regardless of rank, and whilst the senior doctor should ask the further questions of the patient, without excluding the junior doctor. The consultant should “sedulously guard against all future unsolicited interference”.\(^4\) The patient’s condition was not to be discussed in their presence and no prognosis given without it being agreed beforehand. Despite his keen sense of hierarchy he warned against ‘diploma snobbery’ saying that whilst

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\(^1\) Percival, *Medical Ethics*, 1803, I.xviii.

\(^2\) ibid., I.xix and I.xx

\(^3\) ibid., II.v

\(^4\) ibid., II.viii
a regular academical education furnishes the only presumptive evidence of professional
ability ... it is not indispensably necessary to the attainment of knowledge, skill and
experience ... the aid of an intelligent practitioner ought to be received with candour and
politeness and his advice adopted if agreeable to sound judgement and truth ... [since] the
good of the patient is the sole object in view".7

Percival saw consultation as being in the best interests of both patient and practitioner, but
predicated on smooth and uncontentious protocol. He aimed to maintain a hierarchy of medical
practitioners, partly on the basis of “profession” (physic, surgery and apothecary), but also to
promote free “discourse” without “jealousy” amongst those of obvious skill and integrity.

Jukes de Styrap on Consultation

De Styrap’s Code is a strange document in which verbatim quotes from Percival are set within a
somewhat different context. Where Percival counselled compliance with the patient’s view at
almost all times, de Styrap felt able to set out “duties of patients to their medical advisors”. These
amounted to a set of injunctions to consult only orthodox registered medical men, to refuse even
social calls from other doctors whilst ill, and never to seek another opinion without informing their
ordinary medical attendant. The incoming doctor was “morally and ethically bound” to ensure that
his “discarded confrere” was treated well.8 Echoing Percival’s phraseology, but inverting its
meaning, de Styrap stated that diplomas and degrees recognised under the 1858 Act “furnish[ed] the
only presumptive evidence of professional abilities and acquirements”, and thus marked out the
only fitting persons to be met with in consultation. Since “in consultations, the good of the patient
is, or should be, the sole object in view” he generously allowed consultation with foreign graduates
of “good moral and professional local standing”. Homeopaths were well beyond the pale and
excluded from consultation along with unqualified assistants, although the medical employers of
such assistants were not to be offended in any way.9

Tirades against the evils of homeopathy aside, his guidance on consultations was detailed and, by
the standards of his own prose, rather pithy. It marks a half-way stage between Percival’s rules and
the BMA’s later codification. When a patient requested a consultation it was best not to take it as a

7 ibid., II.xi
8 De Styrap, Medical Ethics, 1890, pp. 45 - 46.
9 ibid., pp. 54 - 56.
criticism or to seek to delay it. A consultation with a more junior practitioner should never be declined “merely because he is junior”. Assuming everyone arrived on time, it was “the rule and custom” for the attending practitioner to introduce the case, for the consultant, in most cases to then take on the questioning and examination of the patient. Nothing should be said in the hearing of the patient or their friends until the prognosis and treatment had been agreed in private between the doctors. The family doctor was to enter the sick-room first and to leave last. The consultant should endorse the attending practitioner and his treatment “as far as it can be consistently with a conscientious regard for truth”. Furthermore, the consultant should refrain from “inordinate attentions”. In cases of irreconcilable differences of opinion, the majority opinion should take precedence, with the casting vote going to ordinary medical attendant. Where two doctors disagreed they should endeavour to compromise, or failing that call in a third doctor. Also, rather anachronistically he stated that “the graduate in medicine practising as a physician only is entitled to take precedence over the General Practitioner”. Thus in his codification there was a tension between the precedence granted to the ordinary medical attendant within the “unified profession” and an older scale of seniority based on occupational divisions.

The consultant had “no claim to be regarded as a regular attendant on the patient and his attendance ceases after each consultation”, and invitations to become the regular attendant were to be “firmly declined”. The attending practitioner should make sure that the consultant’s plan was being closely followed. De Styrap also, uniquely, considered fees in a discussion that touched on the subject of dichotomy, without spelling it out. Fees of 2 to 5 guineas were reasonable, but the “anomalous” rural practice of this fee being paid to the attending practitioner, and then passed on to the patient in his bill was condemned.

The Royal College of Physicians of London

The RCP Bye-laws stipulated many aspects of its members conduct towards each other and towards the College. The Statuta moralia of 1647 for instance stipulated that discussion was to be in Latin,
and that "the first medical attendant is to remain in charge of the case and all due care is to be taken not to impair his reputation". In 1862 a new bye-law stated that "if two or more Fellows or Members of the College be called in consultation, they shall confer together with the utmost forbearance", and no prescription or communication to the patient or their attendants was to be made until determined by private conference. Prescriptions were to be signed by all those present, and "if any difference of opinion should arise, the greatest moderation and forbearance shall be observed". Here the College rules differed from de Styrp’s, advising that "the fact of such difference of opinion shall be communicated to the patient or the attendants by the Physician who was first in attendance, in order that it may distress the patient and his friends as little as possible. Furthermore, no member of the College should "officiously, or under colour of a benevolent purpose, offer medical aid to, or prescribe for, any patient who he knows to be under the care of another legally qualified Medical Practitioner".

**Saundby on Consultations**

Despite his long involvement in the BMA and chairmanship of the CEC, Saundby’s ideas on the consultation, and his discussion of it were different in its emphasis to those endorsed by the BMA in 1908. He was most interested in the work of consultants who spent most of their time consulting, and started his treatment with a discussion of specialisation. The existence of such specialisation was due, he said, to the fact that it was impossible to do everything in medicine well. "Special operative skill" and "special study and experience" were "good and sufficient reasons" for the existence of the two classes of consultants; surgeons and physicians. However, he stressed that although high academic titles were by now usual in consultants, these did not define them. He argued that such qualifications were by-product of the necessary experience, and that it was the experience itself that was sought by other doctors. Thus on this model, he conceded there could also be consultation between general practitioners. Thus there was a contrast between Percival, who aimed to promote harmony between quite distinct professions within the "faculty" of medicine, and Saundby, who was trying to justify a division within a supposedly unified medical profession.

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19 RCP(L), The Charter, Bye-laws and Regulations of the Royal College of Physicians of London, 1862, and 1886. The earlier Bye-laws affecting conduct are summarised in Chapter 4.
20 *ibid.*, 1886, Chapter XXVII, Bye-law CLXXIII.
21 *ibid.*, CLXXIV.
Discussing consultations carried out with the involvement of the attending practitioner Saundby followed the lines laid down by de Styrup and the RCP, essentially protecting the position of the attending doctor, and setting out how to avoid public disagreement. However, Saundby also discussed the situation that in which a patient approached a consultant directly. The specific problem was that the patient might be seeking an opinion without the knowledge or recommendation of their attending practitioner, and this left the consultant in something of a dilemma. Rules published by the Birmingham and District General Medical Practitioners Union in 1902 stressed that the consultant should always write back to the attending practitioner when they were referred patients. However Saundby felt the patient had a right to veto a letter being sent to their own doctor, implying that the reasons were consideration for confidentiality and privacy. Thus whilst he recommended that consultants should inform their colleagues of the treatments he was carrying out, and why, he also allowed that the consultant was “not bound to ask” the identity of either the patient or their attending practitioner. He also alluded to his own experiences of writing back to doctors about their aggrieved patients, only to be blamed himself for the patient’s upset. This area was to become controversial again in the 1930s and strikingly the source of the dispute was Birmingham. Why lay consultation patterns should be problematic in this new industrial city and not in others is not clear.

Drafting the Rules on Consultation, 1905 - 1910

The 1905 ARM passed an apparently simple resolution asking the Council, and thus the CEC, “to consider the relative ethical position of consultants and the medical practitioner in attendance to each other, and the patients, and report”. The CEC felt the issue was of sufficient importance to warrant framing their deliberations as “recommendations for adoption by the Representative Body after reference to the Divisions if necessary”. These having been approved by the Association, would “serve as a short code of rules for the guidance of members of the association, and of the profession generally”. Thus the Committee submitted a Report on the subject to ARM of 1906.

The Report made it clear that there was an ethical issue involved in that the consultant, “places himself in a position of trust, which it is unethical for him to seek in any way to convert to his own advantage and to the detriment of the other practitioner concerned.” It was also proposed that

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23 Birmingham and District MPU, Code of ethics, in, ibid., pp 136 - 139.
24 Saundby, Medical ethics, 1907, pp. 24 - 32.
25 ARM 1905.
27 ibid.
doctors had a duty to call in a consultant where this was in the patient’s best interests. Given subsequent criticisms of consultation ethics as “etiquette” it is striking that the CEC also distinguished between these “ethical” considerations and the rules, which they termed “etiquette”. The status of these rules was also a little ambiguous: even before they had been agreed by the ARM some doctors were accusing others of “grave breaches of medical ethics” for contravening them.

Kinsey, speaking during the ARM’s deliberations on the issue in 1907 stated that consensus was important since the documents discussed “ought to be the law of the profession for many years to come”. The report passed (albeit with some alterations) by the 1908 ARM fought shy of such a legalistic status. The preamble stated,

the following rules are put forth as a statement of the customs generally observed by members of the profession, conversant with its best traditions, as governing the relations of “consultants” and “attending practitioners”. Their observance on all occasions would do much to maintain cordial relations between members of the profession.

In other words this codification sought to combine the twin authorities of “tradition” or “custom” with the democratic and disciplinary force of the Association.

However two areas were to prove consistently contentious. The first related to the definition of consultants. It took the CEC two years to decide whether or not to recognise a distinct class of consultants in their rules. They decided not to do so for the reason that the mention of it in the first draft had given rise “to misapprehension as the general objects of the report, and the effects which might be anticipated from its adoption.” Robert Saundby, who had not taken part in the CEC’s work on this issue, had tabled a motion of “regret” that the report had not first been sent out to “some body representing Consultants”. He felt their “concurrence is necessary to the success of any project of reform in procedure”. No such consultation took place.

The final report stated that a consultant was “any practitioner who is called upon to give a second opinion respecting a case already under the care of another practitioner” adding that “the term is frequently used also as the designation of a special class of medical practitioner, distinguished ... by

28 Draft Report, CEC, 10.4.1908.
31 Draft Report, CEC, 10.4.1908.
the fact that a large proportion of the patients attended by him are seen in consultation with, or are ordinarily under the care of other practitioners”\(^\text{34}\). However, the report continued, limiting themselves to the latter definition would have “greatly diminished usefulness” of the rules. The patient’s regular medical advisor, or the doctor already involved in their care, was defined as the “attending practitioner”. The report also stated that,

> many of the difficulties that have now to be overcome would not exist if the consultant could not under any circumstances become the competitor of the attending practitioner. However desirable the growth of such a class of pure consultants may be, it must be recognised that at present the number of practitioners regulating their work on these lines is exceedingly small.\(^\text{35}\)

However, this latter “pragmatic” consideration cannot have been the only reason why the CEC chose to construe the definition of “consultant” as they did. The BMA’s new constitution was intended to promote the needs of the whole profession; thus to construe the profession as having two component halves, the interface of which needed policing would have sat uncomfortably with the project the organisation was meant to be pursuing.

However, the divisions in the profession were apparent in the process of drafting the rules. Robert Saundby raised his objections on an aspect of the rules that were to cause continued controversy in a letter to the *BMJ*. He argued that the duty placed on consultants who were approached directly by patients to communicate first with the attending practitioner “could only do harm” and would be unworkable for ‘pure’ consultants. Although he supported the principle, “even ... some of the most respected consultants” objected to such letters, “on the grounds that [they] often expose them to acrimonious and insulting replies”.\(^\text{36}\)

On the other hand, the amendments suggested by the Divisions after the ARM of 1906 tended to strengthen the attending practitioner’s position. The most striking examples of this are suggestions from Edinburgh and Hampstead to the effect that the “class styled consultants” should not see any patients unless referred by, or in collaboration with their attending practitioner.\(^\text{37}\) The main challenge faced by the CEC was how to manage the myriad detailed amendments put forward in 1907 and at the ARM, and still create a consensus. It was only with some difficulty that Kinsey and

\(^\text{34}\) “Report on Ethics of Medical Consultation (as amended in accordance with the instructions of the Annual Representative Meeting 1909)” in CMAC SA BMA D248.

\(^\text{35}\) ibid.

\(^\text{36}\) *Br. med. J.*, 1907, i: 534.

\(^\text{37}\) Appendix B, CEC s/c, 8.11.1907.
Langdon-Down prevented the Meeting from debating every single possible amendment. The points raised were referred back to the Committee to be combined as best they could. The 1908 ARM a further addition was made when the Report was endorsed, adding to the ethical considerations in consultation; “it is to the patients interest that his confidence in the attending practitioner should be unimpaired”. In the end the rules were issued as a Report because not all proposed amendments had been incorporated. This said the “Report on Ethics of Medical Consultation” formed the basis of much of the BMA’s “ethical policy” during the period studied.

The Report on the Ethics of Medical Consultation

We have already considered the definition of consultants and attending practitioners with which the report opened. As for the ethical basis of the report, it continued, “These rules rest upon certain general considerations which it is thought well to state in view of the misconceptions which exist as to the principles of medical ethics”. The consideration were; that it was “to the public interest” that there was a procedure to facilitate the obtaining of second opinions; and that in doing so it was necessary to protect the interests of the attending practitioner. The attending practitioner should be recognised to be “primarily and continuously responsible for the patient’s medical care” whilst the consultant had “relatively ... temporary responsibility”. It was also “to the patients interest that his confidence in the attending practitioner be unimpaired”. Furthermore, since the rules stipulated communication between doctors, the patients would benefit “because the attending practitioner has a knowledge of the patients past medical history”. Finally the report alluded to “the [position] ... of trust” in which the consultant was placed by the attending practitioner.

Next the report went on to define situations in which it was the “duty” of the attending practitioner to arrange a consultation. These were; where the case was “obscure and difficult”; when the “patient or his friends desire it”, especially where “a dangerous or injurious operation or treatment is under consideration”; where the destruction of a foetus in the interests of the mother was considered; where the diagnosis was in doubt and delay dangerous; where the patient or their friends doubted a diagnosis; and where “an illegal operation, poisoning or any criminal offence” was suspected.

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39 ARM 1908, Min 582.
40 A problem is that amendments and issues arising out of this report continued to be passed between 1908 and 1910. I have based this précis on the version cited in note 34. above.
41 Rules 1 and 2 in *ibid.*
Whilst the choice of consultant was the responsibility of the attending practitioner, he was not justified in refusing a consultant selected by the patient, unless they are not qualified, or they were ethically debarred from meeting them. Those whom the attending practitioner did not have a duty to meet at the patient’s request were unregistered practitioners, practitioners whose “peculiar system of treatment would render consultation futile”, and any practitioner whose conduct had been declared “detrimental to the honour and interests of the medical profession. The doctor who was sought as a consultant by any means other than at the invitation of the attending practitioner, was enjoined to obtain the consent of the attending practitioner, unless the patient forbade it. (This was the rule that had so concerned Saundby.) The report then turned to “the etiquette of consultation”. These rules, the report said, “should be observed unless there is some substantial reason in a particular case”, providing something of a let-out clause for those who chose to ignore them.

The consultation should be held either at the patient’s house, or the consultant’s. The attending practitioner should attend punctually, and if he didn’t appear, the consultant was to leave his conclusions sealed for the attending practitioner to see, thus leaving the attending practitioner in charge of the case. In keeping with antecedent codes, and much as de Styrap had detailed the attending practitioner was to give a history before seeing the patient, then the attending practitioner should enter the room first, introduce the consultant, and leave last. The diagnosis, prognosis and treatment were to be discussed in private, and the agreed opinion delivered to the patient by the consultant in the presence of attending practitioner. If there were differences of opinion the patient should be made aware them when the consultant delivered his opinion. The attending practitioner was advised to ascertain fees in advance so that these could be paid at the time. When the attending practitioner could not attend he should introduce the consultant to the case by letter, and the consultant’s opinion and prescription were to be sent to the attending practitioner under seal. All future appointments were left up to the attending practitioner to arrange.

The report went on in traditional vein to warn doctors to take “great care” in making observations in the presence of the patient, “all criticisms or reflections on the practitioner in attendance must be avoided”. Differences of opinion were not to be revealed, so long as final agreement could be reached. It was the duty of the attending practitioner to “loyally” carry out treatment suggested by

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42 Rule 3, in ibid.
43 This stipulation related to Homeopaths and is discussed in the following chapter.
44 Rule 5, in ibid.
45 Rule 6, in ibid.
46 Rule 7, in ibid.
the consultant and not to alter it unless it had been given fair trial or there were urgent grounds to change course. The consultant should not be “unduly ingratiating” and should not undermine confidence in attending practitioner, and was to communicate with patient and friends only through them. The last rule stated that the consultant could not supersede during the illness that they had been consulted on, and could attend or prescribe in future “only after explanation with the attending practitioner”.

These rules protected the relationship between a patient and their attending medical practitioner (a GP in most cases), whilst ensuring that more expert advice would be readily available, and that such advice would be taken. They set up a system of interlocking duties and responsibilities between the attending practitioner and the consultant. Whilst the wishes of the patient were seen to be paramount, the drafters of these rules evidently wanted to exclude unqualified, unorthodox and ostracised doctors from the process. Most crucially, they extended the responsibilities of the consultant toward the attending practitioner by making it incumbent on him to communicate with the attending practitioner whenever possible, and by banning him from seeing the patient again without the attending practitioner’s consent. The definitions of consultant and attending practitioner were made primarily with reference to their relationship to the patient, not with reference to appointments or expertise.

**Pressure to change the rules resisted, 1922 - 1933**

Throughout the 1920’s and early 1930’s the CEC was constantly invited to strengthen the rules in favour of the attending practitioner. The rules were redrafted 1933-4 after a ‘correspondence of attrition’ conducted by Solomon Wand, a Birmingham GP, who was to play a leading role in the massive Danckwert’s pay award in 1951, and then to become Chair of Council in 1956.

**Free choice of doctor**

In 1922 the ARM passed a resolution asking the Council to consider altering rule 10 of the 1908 rules. This proposed that no medical practitioner introduced as consultant could “undertake sole attendance upon members of that family residing in the same house, except with knowledge and consent of the former medical attendant”. The question was referred down through the CEC to the

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47 Rule 8, in *ibid.*
48 Rule 9, in *ibid.*
49 Rule 10, in *ibid.*
51 ARM 1922, min 71,
subcommittee, who considered preventing a consultant from taking over the care of a patient, partly by de-barring the patient from being seen by anyone who had been used as a consultant. Dr H C Bristowe, a rural GP from Somerset, who served on the committee from 1920 - 1932, argued that such a move would limit the patient’s free choice of doctor. Worse still patients might be forced to continue with a doctor they did not have confidence in, and thus be reluctant to allow a consultation to occur. All this would be far worse in rural practice, where patients could very easily ‘run out of’ alternative medical advisors, or be forced to travel long distances for a second opinion. These objections prevailed, and Anderson, as Deputy Medical Secretary, was asked to prepare a statement explaining this decision. The existing rules were presented as the best trade off between the “feelings of the doctor as to the question of the possible loss of his patient” and the danger that the patient might be “cut off from reasonable possibility of change of doctor”. It was also argued that the rule had been useful and practicable in dealing with cases. The ARM accepted this decision in 1923.

There was also continued evidence of the lack of clear distinction between consulting and general practice. The Hon. Secretary of the Newcastle on Tyne Division stated that,

the medical profession is becoming more and more complex, and there are, at least I feel so, no strict limits put to these spheres of activity. For example may general practitioners engage in general surgery, then there is the ever increasing abuse of Voluntary Hospitals for free consultations without the permission of their regular doctor.

The real danger of supercession in this confusing situation was reflected in the complaints of the Darlington Division over the ‘weakness’ of Rule 10. This Division tabled a resolution at the ARM of 1924 proposing that the consultant must not supersede on any member of the household at any time, except in areas where this is impracticable, in which cases the question should be referred to the Hon. Secretary of the Division. The Representatives declined to vote themselves or their close colleagues into such a delicate role!

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52 Memorandum, CEC s/c 26.9.1922.
53 CEC s/c 26.9.1922
54 Council, 14.2.1923.
55 Letter, CEC s/c, 26.9.1922
56 CEC s/c, 23.11.1923.
57 ARM, 1924 (min 149).
Advice in the literature

That consultation continued to be a bone of contention is reflected in the suggestion of Reigate Division that the rules be published in the *BMJ*.\(^{38}\) They had been available all the time, printed the section dealing with “Decisions of the Representative Body” in the annual *Handbook*, and also as a separate document issued from the Central Office.\(^{59}\) The rules subsequently appeared as an appendix in the *Handbook for Newly Qualified Medical Practitioners* in 1926 and 1935. The 1923 edition had included only a brief summary of consultation ethics.\(^{60}\)

Aitchison Robertson set out a fairly strict set of ethical rules on consultation in 1921 in which the needs of the patient figured far less than in the BMA’s deliberations on the subject. He followed the supposition that “the term consultant means one who consults with another medical man, hence, if he does not do so, then he becomes an ordinary medical adviser and loses that prestige”.\(^{61}\) Robertson stated that when seeing a patient for the first time “it is your duty to enquire how long he has been ill and whether he has already been attended by another doctor” and to find out why they changed. The new doctor must communicate and “ask permission” of the other doctor before proceeding, and failure to do so constituted a “grave breach of medical ethics”, and the Golden Rule.\(^{62}\) Furthermore if a consultant was called directly by a patient the consultant should state that it was “irregular” to do so without introduction and a letter. If he examined the patient “(though this is also a breach of etiquette)” he should write to the attending doctor and inform him, and should not prescribe.\(^{63}\)

The unpopularity of medical etiquette

It is not hard to imagine that consulting doctors who insisted on these forms of behaviour could be frustrating for patients. There is good evidence that such “etiquette” was deeply unpopular. Squire Sprigge’s *Lancet* volume did not aim to deal with “etiquette” (indeed consultation was not covered in the book), but, he said,

> there are sections of the public who still believe that medical men are guided in their behaviour by a set of quaint and secret rules designed to maintain medical interests at the expense of the popular purse. ... treatises purporting to define that code. ... had their danger

\(^{38}\) CEC, 23.9.1924, and *Br. med. J.*, 1924, ii: *supplement* 11.10.1924.


\(^{61}\) Robertson, *Medical Conduct and Practice*, 1921, p. 84

\(^{62}\) *ibid.*, pp. 71 - 2.

\(^{63}\) *ibid.*, p. 83.
... when a practitioner insisted in regarding them as laying down regulations by which the public must be guided, whether in the public interest or no, trouble always occurred.^*

Some doctors simply regarded the public as ignorant of their finer feelings and the considerations they had for each other’s well-being. E Kaye le Fleming’s discussion of medical etiquette, the doctor patient relationship, and public perceptions is worth quoting at length here.

this close relationship [between a doctor and his patient] goes to the very root of general practice ... [but has] given rise to a confusion of ideas in the public mind which may be generalised under the title of “medical etiquette”. This term expresses something of which the public is very suspicious, and which it is apt to reckon absurd, old fashioned, and designed to advantage the profession to the public inconvenience. Doctors, as has been said, recognise this close personal tie between themselves and their patients, and it is a point of honour with them to do nothing that could damage or weaken it in a colleague’s practice. ... The public is at liberty to go to the doctor of its choice, to change from one doctor to another, but there is a right and a wrong way of exercising this choice. And it is generally when the wrong way is being contemplated that we hear criticisms of medical etiquette, which is after all, only another name for good manners as between members of an honourable profession. The bond between doctor and patient must be definitely broken before a new bond with a new doctor is forged, and the reluctance of the patient to face the delicate task of severing the connection is generally the cause of his objection to medical etiquette.^^

Fleming appears to have proposed a kind of “serial monogamy” model of doctor patient relationship, (with the covert consultation perhaps as a kind of extra-marital affair?) which, along with the economic consequences of losing patients may explain something of the “heat” with which GPs discussed the issue. This is to assume that what Fleming writes is representative of a reasonable number of GPs. It can at the very least be read as an interesting justification of what was evidently an area of discord between public and profession and a source of economic sensitivity for ordinary doctors.

Similar views were apparent in cases dealt with by the CEC. For instance, in 1930, a GP had complained that a patient of his had sought a second opinion on her goitre, through her employer, and the physician she saw advised her against an operation suggested by a surgeon, all without reference to him. The reply (presumably from Anderson or Arnold Lyndon) had stated that neither patient nor consultant had acted improperly, and that her desire for a second opinion was

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^* Sprigge, et al., Conduct of Medical Practice, (1927), 1928, p. 2.

^E Kaye le Fleming was a prominent BMA man and General Practitioner. He qualified BA in 1895, and MA MB BC in 1899, all from Cambridge, and having also trained at St George’s passed his conjoint MRCS and LRCP in 1898. Following house surgery and surgical registrar posts at George’s he went into general practice, working in partnership in Wimbourne, Dorset. He rose through the BMA, having chaired the Local Medical and Panel Committees in the late 1920s, and the ARM for 3 years in the early 1930s, to become Chair of Council in 1936. He was also on the Medical Advisory Committee of the Ministry of Health and was a BMA Direct Representative on the GMC.

understandable. Indeed “it would be very hard on her if the consultant from whom she wished to obtain a second opinion intimated to her that he could not agree to the consultation without first communicating to you”. Such reasonableness was soon to be under concerted attack by doctors from Birmingham.

**Solomon Wand lobbies the CEC**

In May 1931 the CEC considered a correspondence of some 5 months duration between the Deputy Medical Secretary (DMS) and Solomon Wand of Birmingham Central Division. Wand’s original query was apparently simple, but addressed the central compromise of the Rules. He asked whether a consultant who saw a patient at his rooms without a referral from a practitioner, and then sent no letter, was guilty of a breach of the Ethical Rules of Consultation. The reply was typical of a non-committal answer from the CEC or medical department to a hypothetical question. It stated that no “fixed rule” could be made for all circumstances, and that whilst the patient’s wishes were important, it was “in the general interests of the patient ... to arrange things formally”.

Wand answered that this reply conflicted with his own reading of the rules and the teaching he had received as a student, based on Aitchison Robertson’s book. The ethical rules, he opined were “worthless unless one can get a clear-cut interpretation”. The DMS promised to put the matter before the CEC, but observed that whilst the views alluded to were seen as ideal, it “has become an accepted practice in large centres of population” for patients to self-refer direct to consultants. This could be self-defeating for patients, but “I cannot agree that the patient has no rights in this matter and that he must necessarily conform to the wishes of his doctor. After all it is the patient who has to undergo the treatment”.

Wand replied that his chairmanship of the Division’s Encroachment Committee made it important that he have “a clear and lucid mind on this question, as a wrong impression may influence me wrongly on important matters.” Wand could not see the point in having rules if population density was a valid basis for special pleading. “There is apparently protection for the consultant ... protection for the patient who may do as he likes (whether it is in his interests or not) but none for

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67 CEC, 14.10.1930.
68 Unfortunately the identity of the DMS concerned is not clear, Forbes was not DMS to the CEC until 1932.
70 DMS, to Wand, 22.12.1931, in ibid.
71 Wand, to DMS, 3.1.1932, in ibid.
72 DMS, to Wand, 6.1.1932, in ibid.
the GP whose interests should be at least on equal consideration as he is the great sufferer.” Wand wanted to know what was “right and wrong” and not “accepted (so-called) practice”.73

The subcommittee had discussed the correspondence in April, and resolved that no new rules were needed to meet the situation as well as pointing out that when it came to concrete cases there was usually no difficulty in using the rules.74 Wand was not deterred, and writing back in July, he said,

I should like to ask again why there should be a difference ethically between a patient seen at his own home or at the consultant’s rooms and why the Ethical Rules should apply to the former and not to the latter. That was my original question and I still have no answer.

This time, he recounted an actual case. One of his partner’s patients had a breast abscess, and was advised that it could be surgically treated. However the patient went without the doctor’s knowledge to a gynaecologist who told her that it could not be operated on at home, and admitted her to a private bed in a hospital. “Is it ethical?”, asked Wand,

according to your letter, yes. The patient did not want to leave her home (where it could have been done easily). Is it in the patient’s interest? She is back home now and the abscess is filling up again. ... This is not the worst aspect ... [the consultants] talk and the patient hangs on their every word [and] frequently gets the erroneous idea that he or she has been treated wrongly. Then there is the man who says outright (and he is not always right) - “your doctor has treated you wrongly” ... in the interests of a welded profession this matter is worthy of the greatest consideration.75

As if to hammer the point home, the same meeting considered another case from Birmingham. Here the consultant had written to the GP only after treating the patient, and repeating a number of tests the GP had already performed. The GP’s response to the consultant’s final letter was furious; “I am most surprised to find that you have examined this patient without any request from me. Since when has it been the custom for consultants in this town to do this?”, and he had declined to treat the patient any further.76 The committee was stirred, and initially decided after “lengthy discussion” that Wand had raised “a number of questions of principle which, in some measure go beyond the rules of ethics of consultation”.77 They later decided that the basic principles hadn’t changed, and they were there to safeguard the interests of all involved, above all (in a rare admission) to protect the GP. Their aim was that in “no circumstances would one practitioner

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73 Wand, to DMS, 9.1.1932, in ibid.
74 CEC s/c, 22.4.1932.
75 letter, Wand, 28.7.1932 in D248.
76 ibid.
77 CEC, 1.11.1932.
displace another without communicating with his colleague with a view to securing either co-
operation or a clear understanding that responsibility has been transferred.” However they still had
to concede that the patient had the right to forbid the consultant to write to the attending
practitioner. 78

A number of points arise from this correspondence. Firstly there was a conflict between the case-
by-case approach of the CEC and the desire felt by some doctors for a set of watertight rules.
Although the 1908 rules were more detailed than any other codification of the subject, and had the
prestige of the Association behind them, they were still not couched in absolute legalistic terms, and
were, as Wand pointed out open to abuse. Most importantly they left “it open to the unscrupulous
consultant to suggest that [his not writing] is on the patient’s command”. 79 The second point related
to the nature of the rules themselves. They were, as the preamble had pointed out, a codified form
of “best traditions” and the practice of doctors in certain areas was changing. The natures of
consulting and general practice were relatively fluid, and still changing. Should the BMA “give in”
to new “traditions” or try to hold the line in some way? Lastly the story brings out the casuistic bias
of the Committee. The CEC did not shift from defence to reconsideration of the rules until cases
were presented by Wand and others. However the attempt to tighten these rules and bring them up
to date was difficult, and did not yield all that Wand, and those who thought like him, would have
wished.

New Rules 1933 - 34

The CEC instructed the subcommittee to redraft the rules of consultation in March 1933, 80 and they
were ready for consideration by the Council the following January. The subcommittee had added
three rules to cover the situations which Wand had raised, and had taken the opportunity to include
rules on “medical inspectors”. 81 These rules covered the etiquette and ethics of the increasingly
common kind of clinical encounter where the doctor was acting on behalf of an organisation or
official body. 82 When Hawthorne, by then the Chair of the CEC, presented the draft rules to Council
he outlined why they had been considered necessary. His discussion revealed something of the
CEC’s thinking on the problem and outlined the compromise they had made. These rules, he said,

78 CEC, 8.12.1932.
80 CEC, 14.3.1933.
81 These rules had been presented originally to the ARM in 1911.
82 Dupree, Marguerite W, 'Other than healing: medical practitioners in the business of Life Assurance during the 19th and
early 20th centuries', Social History of Medicine, 1997, 10: 79 - 104.
addressed the situation in which a patient approached a doctor without their own doctor's knowledge, and on which "two extreme views" were held.

One was that every practitioner was concerned simply with his own interest and his own pocket. ... He was in the position of a shopkeeper, and where the customers came from and where they went to was no concern of his. On the other hand the view was held that no practitioner should offer ... [such a] patient either examination or advice and treatment. The CEC had not adopted either of these extreme views. It considered that every practitioner owed an obligation to the reputation of his profession and owed also consideration and courtesy to his colleagues. On the other hand the public had its rights as well as medical practitioners, and there was a custom firmly established on the part of members of the public to approach members of the profession directly, especially, ... such as enjoyed, rightly or wrongly, the titles of "specialist" "expert" or "consultant".83

Council ordered the publication of the draft rules and report in the BMJ supplement for consideration by the Divisions.84 There were several differences from those of 1908. There was no preamble, a new "circumstance" in which consultation was "desirable" was where continued treatment with a drug scheduled under the Dangerous Drugs Acts (1920 and 1932) was considered. A new section, "other intra-professional obligations" was introduced which included the three new rules.

Rule II.1 stated that a doctor was free to treat anyone who had no doctor and who approached them for treatment, but that if he had already seen them in consultation or as a locum, then they should provide only emergency treatment and "forthwith explain the situation to his colleague". Rule II.2 stated that when taking over a case the practitioner "must satisfy himself that the other practitioner has been duly informed ... that his services are no longer required". Rule II. 3 stated that when approached by a patient the doctor "has reason to believe ... is already under medical care" and is coming without their doctor's knowledge "it is the[ir] duty ... to urge the patient to permit him to communicate with the attending practitioner." If this were refused, the doctor could examine, but not take on the treatment of the patient. Rule II. 4 covered the analogous domiciliary situation; the invited practitioner had a "duty" to ensure that the attending practitioner was informed before he went ahead. He could however treat the patient if the attending practitioner refused to attend and the relatives or the patient persisted in their request.85

The rules for medical inspectors essentially said that the attending practitioner should be invited to any visit by the medical inspector, except in urgent circumstances or where there was no attending

84 Br. med. J., 1934, i: supplement 3.2.1934.
85 ibid.
practitioner. The inspector could see the patient alone if the attending practitioner did not respond, or did not attend. The inspector was not to do any more than was necessary for the making of his report, or to interfere with any treatment or criticise the attending practitioner.

The document generated a large and immediate response. Most of the comment was reserved for the new rules, particularly Rule II. 3. Birmingham Central wanted to bar all pure consultants from seeing non-referred patients at all, and others echoed this idea, less strongly. Oxford thought the rules needed “strengthening”, whilst Nuneaton and Tamworth wanted to replace all the new rules with the simple duty on consultants to ensure there was no attending practitioner. Rochester Chatham and Gillingham Division tabled a motion attacking the CEC, and its interpretation of rules and principles. They had resolved that

in view of their loss of confidence in the interpretation by the CEC of the existing rules of conduct is of opinion that although the new rules are satisfactory so far as they go, they should be framed more categorically in order that no Ethical Committee should have any latitude in the interpretation of principles and that no medical practitioner can be in any doubt as to the propriety of his actions. 86

Barnsley Division were of the opinion that “the published ethical rules relax the customary practice rather than strengthen it”.

In contrast several divisions north of the Scottish border had quite different objections. Glasgow Division moved that “throughout broad principles are stated in too dogmatic a form” and stressed that,

the patient has continuously has the right to the services of the doctor of his choice, and the doctor equally to give or withhold his services: the point is that any change in the status proens should be done in a courteous manner. The present unwritten but courteous methods employed might be described in these rules. 88

Edinburgh and Leith Division pointed out that it had “never adopted the ordinary Ethical Rules of the BMA and therefore is inclined to look upon the foregoing as “suggestions” rather than rules”. 89

At the 1934 ARM most of the amendments calling either for relaxation of the rules or their tightening were lost. Birmingham Division having lost their original motion, immediately proposed

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86 Memoranda submitted with minutes, CEC, 12.3.1934, in CMAC SA BMA D249.
87 ibid.
88 ibid.
89 ibid.
a new version of their amendment and put it to the meeting again. This allowed the consultant to treat if he “had reason to believe” the patient was not under another doctor. This was passed, thus allowing Birmingham to get some of what they wanted. Proposals to make consultants decline to treat patients who would not allow correspondence with their attending practitioner were lost. Essentially the new rules were more explicit, but little more strict on this question of communication with the attending practitioner than those passed in 1908.

Birmingham Division did not rest content with the new rules. At the 1938 ARM they proposed a new Rule II.1, which would have subtly increased the obligation of consultants to attending practitioners, had it not been defeated after a long speech by Hawthorne. Not that he disagreed with Birmingham on principle. In his article for Practitioner published in 1936 he said that the patient who seeks an independent opinion without reference to his or her own doctor “fails in courtesy and even ... in wisdom”. Although “a patient is not the property of any individual doctor” and can choose, even if choose on wrong grounds, his advisor,

> professional seemliness demands that the second doctor shall communicate with the attending practitioner, and should the patient refuse to allow this proposal then the “consultant” should decline to accept him as a patient. This is to affirm two principles - one that the proposal is in the patient’s interest, and the other that courtesy and regard are due to a medical advisor ... 91

But it appears that principles were one thing, and strict codified rules another. Thus, running through this episode, which on a superficial reading would appear to be a straightforward process of codification and adjustment, there was a deep, but unstated assumption that the “ethical ball” was firmly in the practitioner’s court. Doctors were not to be regulated by the precise letter of an ethical code, they were to be reminded of higher ethical principles and considerations of honour, and prevented from slipping more than a certain distance from them.

90 ARM, 1934, Mins 325 - 344.
**Dichotomy**

Dichotomy or fee-splitting is the hidden ‘shadow’ of consultation and its ethics. Thus, whilst the generalist depended on the specialist for expert help and advice, the specialist depended, unless approached directly by the patient, on generalists to provide him with work. Dichotomy involved either the paying or retention of a secret commission to or by the GP. It seems likely that this was the reason de Styrap disapproved the “anomalous” rural practice in which it was the attending practitioner who paid the consultant. The Prevention of Corruption Act 1906 included dichotomy as a secret commission which was legally defined as a conspiracy to defraud. Fee-splitting thus constituted a civil wrong against the patient and a criminal offence regardless of whether or not the transaction could be demonstrated to have been harmful in the case concerned. In civil law, parties were liable to return all they had gained plus five percent in interest to the injured party (the patient). In criminal law the parties were liable for a fine of £500 or a term of two years imprisonment and were also liable to erasure from the the Register.

The problem of dichotomy was often presented in British discussions of it as a vice of foreigners. Thus Saundby, whilst condemning it, described it as a particular problem in France. He alluded to a BMA Council resolution against it in 1899, which in fact called on the London Chamber of Commerce to substantiate “grave general accusations impugning the probity of the medical profession in the matter of receiving secret commissions”. The resolution went on to say that “should such practices exist” that they would “emphatically ... condemn them as a grave breach of professional good conduct and inconsistent with membership of the BMA”. It seems likely that the 1906 Act was passed in response to this and similar accusations, but Saundby also stated that the specific inclusion of medical fee dichotomy in the Act had been based on an exaggerated idea of the extent of dichotomy and commission taking.

The true extent of dichotomy, like that of abortion, was, and is, impossible to know. Unless the patient discovered it, or one of the doctors was sufficiently disgruntled with his partner in crime, it would never come to light. Thus conflicting ideas of its prevalence were apparent in the 1920s.

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92 De Styrap, *Medical Ethics*, 1890, p. 61.
96 Council, 12.4.1899.
when the issue was raised in Birmingham. The consultants and general practitioners who attended the packed meeting at the Birmingham Medical Institute in March 1924 certainly thought it was a problem. Unanimous resolutions were passed stating that it was “improper” for a consultant to hand back any fees to the practitioner calling him in. The consultant would be suspected of “paying a commission” and “the practitioner ... cannot maintain the position of a trusted an unbiased adviser as to the need for a consultation and the selection of a consultant”. They also resolved that no consultant should pay an “inclusive” charge for an operation carried out with help or co-operation of a GP without telling the patient.  

Prompted by this letter, the BMJ carried an editorial which described dichotomy as “inimical to the best interests of the patient and injurious to the moral standards of the practitioner”, but something which “has not, we believe, been common in this country”. It was a problem in Paris, and in the USA and the American College of Surgeons would exclude any member who was suspected to be a fee-splitter. The BMJ editorial hoped the Birmingham meeting would “prevent the continuance or spread of an objectionable practice”. Correspondence on the issue did nothing to clarify the question of prevalence. Vincent Norman, a surgeon in Bradford, stated that this “pernicious form of professional backsliding ... appears to be particularly rife in the Birmingham area”, but argued that patients preferred all-in fees, so long as they knew who got what out of it. The next week a Bromsgrove practitioner wrote to say that he had been in practice near Birmingham for 35 years and had never come across dichotomy. In his experience consultants’ fees were only discussed to try and keep them down for poorer patients.

The issue was raised ten years later in London, by a solitary letter from a young surgeon that had in fact been refused by the BMJ, quite possibly since it was anonymous and detailed a number of crimes. The Lancet carried the letter from “Unwilling Accomplice” in March 1933. It stated that “the alternatives before me are to connive in dichotomy or to lose a large part of my practice”. He was not concerned with the (illegal) situation “in which the consultant and the general practitioner amicably conspire to split the fees between them”. He had never been party to it, and did not know

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99 Leake’s cynical discussion of the hedonistic “ethics” of the profession was partly in response to the widespread practice of dichotomy. A book dealing with the subject was published in the USA: Baldwin, J F, Fee splitting by physicians, Columbus, Ohio, 1926. (Leake, Percival’s Medical Ethics, 1927.)
103 See documents bound with cutting in CMAC SA BMA D238.
how prevalent it was. "Unfortunately," he said, as his letter became steadily more sarcastic, "those who grow fat on [dichotomy] maintain a reticence on the subject that makes it impossible for the rest of us to benefit from their valuable experience". He was victim to being paid out of the GP's bill, in one instance he was paid 40 guineas out of a fee of 75 and in another he received only 20 guineas for an operation for which the patient had paid a fee of 60 guineas. Such practices involved "at least half the practitioners who call me in".104

The next week the *BMJ* carried an editorial on fee-splitting which rehearsed familiar points, but also formulated the link between ethics, interests and the public weal. Dichotomy was, the *Journal* said

a threat alike to the honour of our profession and the to the public interest. The proper and hence happy adjustment of the relations between practitioner and patient can only be secured when the interests of both are identical. ... [The GP's] high reputation and the universal trust accorded to him are based, more than on any ground on a recognition of mutual interests.105

The CEC a few days later asked its sub-committee consider the question. They drafted a resolution defining the practice, and stating that it was "highly detrimental to the honour of the medical profession".106 When this came up for debate at the ARM Bishop Harman wanted the wording changed to state that dichotomy was rare, since he had never come across it in 30 years, but the meeting passed the resolution unchanged.107

"Accomplice’s" letter also produced a statement of condemnation from Norman King, President of the GMC, in his presidential address that summer, stating that if such a practice were proved before the Council it would warrant erasure from the Register. The BMA *Handbooks* for practitioners increased the attention given to dichotomy in each edition - the first having failed to mention it at all.108 It appears that each 'exposure' of the issue increased the advice given. However the problem did not disappear, and the BMA received many enquiries on the subject through the period 1940 - 1961, which I have not examined in detail.109

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106 CEC s/c, 19.4.1933.


109 See: CMAC SA BMA D238.
Cronin in his polemic novel *The citadel*, published in 1937, implied that dichotomy enabled mediocre “consultants” to build up huge lucrative practices. At one of the turning points in the story, the hero Manson’s colleague Freddy suggested a collaboration with another surgeon, to “skim the pool” saying, “You haven’t been getting your proper whack. Don’t you know that when Ivory gets a hundred guineas for an operation he hands back fifty - that’s how he gets them you see!”

If we take statements like those of Bishop Harman and Cameron Kidd at face value (and there is no particular reason to suppose they were not in earnest) it would seem that two quite different worlds co-existed. What was a way of professional life for some was an unknown world to others. Kaye le Fleming, another BMA “insider” writing for young GPs and medical students commented that dichotomy was, once started, easily excused, always concealed and thus “soon deep-rooted once the seed is sown”. In the long tradition of alluding to the judgement of the doctor’s own conscience he said,

> Let the participants of such an arrangement put to themselves a simple question. Is this division of fees one that we are prepared to submit to the criticism of our patient and fellow-practitioners? In some other countries the scandal of fee splitting has reached a situation which is much to be deplored. In this country the profession takes pride in a high ethical standard which it is the duty of every doctor to maintain.

**Discussion**

In addition to the points raised in the main body of this chapter, I should like to draw out some other observations. The BMA’s rules on consultation were designed to ensure that doctors selected the best consultants for their patients without the fear of supercession or the favour implicit in dichotomy, or indeed without undue emphasis on the status of the other doctor. It is unsurprising to find that the rules acted in the interests of ordinary doctors. The notion that medical etiquette was simply self-serving is challenged by the Association’s consistent defence of the rights of patients to consult without their usual doctor’s knowledge, and the extent to which the CEC considered the effects of its rulings on patient care and choice.

The BMA, in contrast to other codifiers of medical ethics and etiquette laid considerable store by a doctrine summed up by Hawthorne in 1938. He said,

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112 *ibid.*, p. 143.
a consultant was not produced by living in a particular street or by association with some college of physicians or surgeons. He was produced by the facts of the situation. ... Any practitioner who was called upon and consented to give a second opinion directly or indirectly upon a patient was for the time being a consultant and had a consultant's status and obligations.  

This refusal to divide the profession paradoxically coexisted with the obvious use of the rules to protect general practice by protecting the status of the patients ordinary regular medical attendant. This rather radical stance was applied to a set of rules that differed little from many that were proposed during the nineteenth century, and in which the “hand” of Percival can clearly be seen. Indeed the division of opinion within the Association (which the Association was fighting to prevent becoming an institutionalised split in the profession) contributed to the survival of both the traditional tenets of consultation ethics, and the compromise position arrived at by the CEC. That said, the deliberation of this code was one in which every tiny piece of ground was fiercely contested.

The ethical rules on consultation rested on a number of assumptions, which they were designed to perpetuate. These were, that the interests of patients and practitioners were, or should ideally be, in harmony with each other, that medical men had obligations to each other summed up in the Golden Rule, and that whilst rules could outline minimum standards, the individual practitioner must be guardian of his own conscience. They also underpinned a pseudo matrimonial model of doctor-patient relations in which the patient was almost regarded as the property of the doctor, and into which rules and regulations intruded little. However the rules carefully prevented another medical man from putting asunder those that the mysterious forces of the medical marketplace had joined together.

Chapter 8

“Those other practitioners”: ethics and the boundaries of the profession

Introduction

In this chapter I shall deal with a set of linked themes concerned with “others”: those outside the orthodox registered profession of medicine. As we have seen, for those within the profession “the Golden Rule” was proposed as the prime ethical principle, whilst for those who transgressed locally agreed stances on appointments no treatment, it seemed, was too harsh. This stark behavioural contrast reflected the importance of the boundary between those ‘within’ and those outside a particular set of practitioners. The ‘inclusion criteria’ for this group of insiders appears to have been education and training enabling registration, orthodoxy, gentlemanly conduct, and solidarity.

The GMC had been prevented by the 1858 Act from enforcing any particular theory or practice of medicine on the registered.1 I shall first turn to the position of medical homeopaths who whilst being registered, were not orthodox and who therefore contravened some, but not all of the ‘inclusion criteria’ for the profession. The ARM raised the issue at the same time as consultation ethics generally and the CEC arrived at a formulation that essentially allowed those with differing tastes and prejudices to behave towards these doctors as they saw fit. Thus although the Medical Act allowed “a practitioner trained and tested in the knowledge essential for public safety, [to] adopt any theory of medicine or surgery in which he honestly believes”,2 any doctor taking up this offer to practice homeopathy could find himself in a very difficult position.

Next I shall consider another set of ‘half-castes’: the large group of unqualified assistants employed by doctors, or by doctors’ employers, in the late nineteenth century. The GMC invented the disciplinary offence of “covering” to describe any act by a registered practitioner that enabled an unregistered practitioner to act as if they were a registered doctor. This idea dovetailed with Council’s statutory duty to enable the public to differentiate between the “duly qualified” and other practitioners. This concept was later extended to cover interactions with rank outsiders like bonesetters, osteopaths and other “quacks”.

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1 Medical Act 1858, Section XXIII.
2 GMC, Memorandum, 1926, p. 5.
The concept of "quackery" itself is historically problematic as Porter, Bynum and others have shown, and some of the themes brought out in their volume *Medical fringe and medical orthodoxy* (1988) are a helpful introduction to this chapter. Quackery and orthodoxy have evidently contained shifting sets of ideas and practices, and have interacted within the wider social fabric. Bynum and Porter point out that, "all schools of medicine took on their identities - shifting all the time- in relation to perceived rivals, above, below and all around" and indicated that they should "be studied in their mutual, dynamic relations, as a whole." Indeed it was the central curiosity of the British "Quackery Scare" of the 1830s and 1840s that quacks were not particularly numerous or well-organised, or indeed creating hardship for doctors. Several writers observe that it was the increasing numbers, organisation and assertiveness of orthodox practitioners that "produced" sectarian "alternatives" like Thompsonian herbalism and problematised the existence of prescribing druggists. Orthodoxy evidently needed quackery to help define itself and it would be hard to imagine a drive for Medical Reform without the drive to legally suppress "quackery" that was integral to it. A profession, like a nation state, needs enemies as well as allies.

The distinction between the registered medical practitioner and the "quack" is one that runs through many of the discourses, particularly on advertising, with which the rest of this thesis deals. We can understand the charge of "quackery" as one liable to be made by any doctor or group of doctors who disapproved of the conduct or practices of another practitioner, or group of practitioners claiming a place in the medical marketplace. In the remaining part of the chapter I shall deal with a number of case studies reflecting the importance of ethical codes in negotiating the relationships between groups of orthodox, 'auxiliary' and 'alternative' practitioners. The fundamental question at issue in these sets of relationships was whether the other group of practitioners accepted or challenged the medical profession's claim to superiority and the insistence of orthodox doctors that they could interact only with those they could supervise.

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3 *ibid.*, p. 4.

4 Neve, Michael, 'Orthodoxy and Fringe: medicine in late Georgian Bristol', in *ibid.*, pp. 40 - 55; Loudon, Irvine, "The vile race of quacks with which this country is infested", in *ibid.*, pp. 106 - 128.

All changed: from Percival to de Styrap

The shifts outlined above are obvious in the contrasts between de Styrap’s Code and Percival’s Medical ethics. Percival’s Code was shot through with a (typically British?) indeterminacy about the boundaries of the group he was addressing. Sometimes it was “the profession” sometimes “the Faculty” and at others the constituent groups of physicians, surgeons and apothecaries. It is striking that whilst he dealt with both consultation and quack nostrums, the question of dealing face to face with “quacks” did not appear in his Code.8 De Styrap’s work was, as we have noted, a diatribe against those who let down the profession from within, through jealousy and bad conduct, and those who threatened it from without; quacks, amateurs and homeopaths. He was writing in a context in which a single medical profession had been designated by statute. “Medical ethics”, he said, having set out the duty of medical men to attend the sick without consideration for their own health or interests,

*cannot be so divided as to entail the ... force of moral obligations on medical men, and, at the same time, free society from all restrictions in its conduct to them; leaving it, moreover, to the caprice of the hour to determine whether the skilled practitioner shall be ignored in favour of the charlatanic pretender.*9

The choice was between the “rectitude and sincerity of purpose, the honest zeal, the learning and impartial[ity] ... of the duly educated practitioner” and the “low arts and crooked devices, and purely selfish ends of the charlatan, whose unscrupulous announcements of professed marvellous cures by simple, but secret means are misleading and false and ... fraudulent.”10 In the long passages that follow it becomes clear that he objected particularly to the use of the press in advertising secret remedies and practitioners, and to abortionists, VD treatments and sexual advice.11 He went on, echoing Hastings’ phraseology to denounce “various popular delusions which, like so many epidemics” were “alike averse to medical logic and ethical propriety”, and the “new and infallible systems of medicine” which found ardent promoters in the clergy. Their good intentions were no defence for ignorance.12

In the context of the general framework set out in the introduction to this chapter it is unsurprising that de Styrap appears so troubled by homeopaths. Having said that, only registered practitioners

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8 Percival, Medical Ethics, 1803, III.i - vi.
9 de Styrap, Medical Ethics, 1890, pp. 19 - 24, and p. 21.
10 *ibid.*, p. 21.
11 *ibid.*, pp. 24 - 25.
should be met with in consultation, he went on to exclude homeopaths, regardless of registered status. “No one” he argued,

can be considered a regular practitioner, or a fit associate in consultation, whose practice is based on an exclusive dogma, such as Homoeopathy, *et hoc genus omne* (unqualified assistants included) - indeed for a legitimate or orthodox practitioner to meet a professor of homoeopathy in consultation, is a dishonest and a degrading act: dishonest, because he lends his countenance to that which he knows to be dangerous fallacy - and degrading, inasmuch as he has neither the manly, professional honesty to resist the temptation of a possibly liberal fee, nor the moral courage to discountenance the capricious vagaries of some wealthy, or may-be titled patient.¹³

However by this 3rd edition de Styrap had received a large amount of correspondence on this question, which he discussed in a huge footnote. Some of his correspondents had argued that “conscience” could indicate that it was in the patient’s interests to provide them with a correct and safe opinion, rather than to abandon them, as it were, to the deadly clutches of the ignorant homeopath. One had argued that the “good Samaritan act” would be to take the case over. Thus whilst he quoted no views sympathetic to homeopathy, the moral language employed by de Styrap, particularly interesting in its denunciation of ‘tainted fees’, could be turned to other conclusions. He concluded that this was a matter for individual conscience.¹⁴

Whilst the RCP did not have any regulations on homeopathy *per se*, a resolution of 1881 can be interpreted as having a bearing on it, (as well as advertising,) since “Homoeopath” was a “designation” if nothing else. The resolution stated that,

> whilst the College has no desire to fetter the opinion of its Members in reference to any Theories they may see fit to adopt in connection with the Practice of Medicine, it nevertheless considers it desirable to express its opinion that the assumption or acceptance by Members of the Profession of designations implying the adoption of special modes of treatment, is opposed to those principles of the freedom and dignity of the Profession which should govern the relations of its members to each other and to the public. The College therefore expects that all its Fellows, Members, and Licentiates will uphold these principles by discountenancing those who trade upon such designations.¹⁵

Saundby’s comments on consultation with the qualified heterodox were less stringent than de Styrap’s, and resolved the problems set out in de Styrap’s troubled footnote. Consultation with members of a medical “sect” such as homeopathy was permissible when the unorthodox

ⁱ³ *ibid.*, p. 54.
⁴⁴ *ibid.*, pp. 53 - 55.
⁵ Resolution of 27.12.1881, see: RCP(L), The Charter, Bye-laws and Regulations of the Royal College of Physicians of London, 1933.
practitioner called in the orthodox man, but it was unethical for an orthodox attending practitioner
to call in a consultant belonging to a “sect”.

**Homeopathy and the BMA**

Not that the position of homeopaths generally had been resolved. During the debate on the ethics of
consultation at the 1907 ARM, some representatives felt homeopaths should not be met with, whilst
others pointed out it made no sense for the Association to draft rules preventing consultation
between various types of its members. In 1908 there was further discussion and the question of
excluding homeopaths from the Association was raised. Many representatives felt they should,
whilst others argued that the Association needed to be “broad”. A sticking point was the use of the
“special designation” and the existence of the *Homeopathic Directory*. Kinsey, on behalf of the
CEC stated that it couldn’t make a hard and fast rule, and that it was up to the individual doctor to
decide. However, the ARM asked Council “to consider the whole question of the relation of
homeopaths to the Association”.

The CEC split the matter into a number of aspects; admission to the Association, remaining a
member, and the “degree of professional recognition” such practitioners should be given. They
noted that past condemnation of homeopaths and attempts to get them barred from Association
membership, contrasted with the fact that no one had ever been expelled simply for being one.
Whilst election was at the discretion of the Branch Council, the only stipulation for membership
was that the practitioner must be registered, and they noted that whilst some Branch Councils had
not elected homeopaths as members, even the anti-homeopathic Branches had never applied for an
expulsion.

The CEC recommended that

> the Association should not attempt to pronounce, in this or in any other connection, what
constitutes sound doctrine in medicine or surgery, nor condemn individual practitioners on
the ground that they hold particular views of pathology or treatment, or to give effect to
such views in the practice of their profession.

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20 ibid.
It was, however “contrary to the recognised principles of medical conduct for any medical practitioner to advertise the holding of peculiar views of pathology or treatment, or the fact that his practice is based thereon as a means of attracting to himself patients”. Furthermore, publication of names in the *Homeopathic Directory* or “similar compilations” and the “use of door-plates or similar means to intimate to the public that they are guided ... by peculiar theories” were undesirable. Thus Branches should not admit those they feel have behaved in these ways, and the CEC and Council would await any request for expulsion they might wish to bring. Discussing this report, the ARM once again became polarised between those who simply wanted to exclude homeopaths, and those who saw that the matter was one for careful thought. It was pointed out for instance that no-one would look in a homeopathic directory unless they already wanted to consult a homeopath.

Despite these differences of opinion the Association adopted the Report, which brought it into line with the RCP and with the GMC. Like the latter body the Association’s members only had to be registered and were stated to be free in matters of theory and practice, but like members of the RCP “trad[ing] on such designations” was frowned on. Since the CEC regarded even the publication of practitioner’s name in the *Homeoeopathic Directory* as unethical, and had suggested that consultation with such practitioners might be “useless” in the rules on consultation, the BMA homeopath who actually identified himself as such could expect to find himself in tolerated isolation. Indeed Minty commented that because of ostracism “homeopaths are a medical sect who are forced to keep entirely to themselves”.

The GMC, unqualified assistants and “Covering”

The GMC was set up to enable the public to differentiate between the registered and the unregistered practitioner. Thus whilst it had no concern with unregistered medical practitioners as such, it was deeply concerned and still is with the imposture of registered status in various forms. This, to modern thinking, occurs most obviously in the form of the “Paper Mask” syndrome where lay people pose as doctors within a complex medical system, almost always in hospitals. In the late nineteenth century not only did the unregistered pose as regular doctors, some were employed by doctors to carry out their work, and, most worrying for the GMC, to issue their certificates. In

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21 ibid.
1883, the Council resolved that it wished to see those who behaved in this way liable at law in exactly the same way as those who straightforwardly imitated a registered medical practitioner. In 1887 they resolved to publish their earlier resolution as an advertisement in the medical journals in order to draw attention to it. When asked to produce a more precise description of the offence the Executive Committee simply stated "without attempting to make a formal definition of the misconduct" that a doctor would be liable to censure where a unqualified assistant was employed "on behalf and for the benefit of such registered practitioner, either in complete substitution ... or under circumstances in which due personal supervision and control are not, or cannot be, exercised by the[m]". The term for this offence was also defined. "A registered practitioner covers an unregistered person when he does, or assists in doing, or is party to, any act which enables such unqualified person to practice as if he were duly qualified.

In the subsequent decade the Council erased a number of practitioners, but the distinction between employing assistants and covering practitioners was blurred, the offence often being described as "covering an unqualified assistant". The Minutes and Smith’s index both indicate that the vast majority of these cases involved formally employed assistants. The systematic use of unqualified practitioners by Medical Aid Associations was brought to the Council’s attention. In 1893 the Council resolved, with reference to their Report on these Associations, that the “Rules already laid down ... as to “covering” unqualified assistants” should apply to medical officers working for Aid Association that also employed unqualified persons as if those doctors had themselves employed them. It was also clear that in coal mining areas of Wales and Co. Durham the use of these assistants by doctors was endemic.

In 1897 the Council decided once again to try and make their point more forcefully, firstly by publishing their Report but also by making their disapproval “clearer and more stringent”. They formally gave “notice that on and after the 1st January 1900 the employment of any unqualified assistant ... will be treated as an offence under the Medical Act” but that the work of medical

26 GMC, Minutes, 1883, XX: p. 91. (21.4.1883)
27 GMC Executive Committee (Mr Bryant), “Report ... [on] the Employment of Unqualified Assistants, and on ‘Covering unqualified persons’”, in, General Medical Council, Minutes, 1897, XXXIV, pp. 116 - 7.
28 GMC, Minutes, 1888, XXV: p. 142. (27.2.1888). Forbes, in Sixty years of medical defence, (1940), claimed that the Union had lobbied the GMC consistently on impersonation and covering, and claimed the credit for the changes outlined above. Unfortunately the GMC’s own Minutes neither corroborate nor disprove this claim.
30 GMC, Minutes, 1893, XXX: p. 64 (26.5.1893).
31 “Report ... [on] the Employment of Unqualified Assistants ...”, in ibid, pp. 119 - 20.
students and supervised nurses, midwives and dispensers was exempted. The resulting Notice published in the medical journals once again distinguished between employing assistants, and covering practitioners. Unqualified assistants, the Notice stated, had been “allowed ... to attend or treat patients in respect of matters requiring professional discretion or skill” and “the substitution of the services of an unqualified person for those of registered medical practitioner is in its nature fraudulent and dangerous to the public health”. However the Council also broadened their definition to include all kinds of association with the unregistered.

any registered medical practitioner who by his presence, countenance, advice, assistance, or co-operation, knowingly enables an unqualified or unregistered person (whether described as an assistant or otherwise) to attend or treat any patient, to procure or issue any medical certificate ..., or otherwise to engage in medical practice as if the said person were duly qualified and registered, is liable to have his name erased from the Medical Register...

The employment of unqualified assistants appears to have ended promptly on the publication of this notice. Indeed Robert Saundby stated in 1907 that prior to the GMC ban, contract practice doctors had earned high incomes on the basis of using unqualified assistants but that now the GMC had “thrown the burden of this work on the qualified man” they were demanding better pay. The sources available to not allow the clarification of whether many complaints of covering were actuated by medico-political shrewdness, or whether the GMC itself foresaw the outcome in this respect. What is clear is that this rule was capable of quite broad interpretation, and continued to have important “uses” beyond the realm of contract practice.

The Axham Case, bonesetters, and an attack on the GMC

The material indicated between ¶ marks also appeared in my 1994 paper, “The medical pundits”, (in appendix B).

The Axham case, which involved covering an unregistered bonesetter by administering anaesthetics, would have been unusual even if it had never become a cause célèbre in the 1920s, yet its later status marks it out as an important event in the relationship between the profession, the public and unorthodox practitioners. Examination of Smith’s index of cases indicates that the vast

32 ibid., pp. 120 - 121.
33 ibid., pp. 121 - 2.
34 Saundby, Medical ethics, 1907, p. 18 - 19.
35 Axham qualified LRPC MRCS in 1861 from St George’s Hospital. He had served as Surgeon in chief to the Franco-chinese forces and as North District Surgeon, British Honduras, before returning to Britain, where, in 1910 he held a post as MO to Westminster Union workhouse. Medical Directory, 1910.
majority of cases of covering involved unqualified assistants before the turn of the century, and unqualified midwives and dentists thereafter, rather than association with an unorthodox healer.\textsuperscript{36} In all the GMC heard 62 cases of covering or employing unqualified assistants between 1886 and 1901, (4.5 cases/year) after which, as Michael Heseltine noted “unqualified assistants were dismissed wholesale”.\textsuperscript{37} Another group of 16 cases was heard between 1906 and 1912, (2.5 cases/year).

Axham’s offence was that of administering anaesthetics for a bonesetter named Herbert Barker, (1869 - 1950) who went on to be knighted, having practised in London since 1905. Bonesetters had been an identifiable group of healers for centuries, often being described as a group of untutored practitioners, who “inherited” their skills and passed them on, practitioners of “an ancient craft”.\textsuperscript{38} The medical profession had not been entirely antagonistic to bonesetters. A doctor, Wharton Hood, had written up the methods of another famous bonesetter, named Hutton, in a warmly received book in 1871.\textsuperscript{39} James Paget, despite characterising the bone-setter as the enemy-to-be of his audience of medical students, and rubbishing their more dramatic claims, pointed out that there was much to learn from the ways in which these practitioners exploited gaps in medical learning and skill.\textsuperscript{40}

One of the standard treatments of bonesetters, styled “breaking down the adhesions” could be extremely painful and Frederick Axham, having convinced himself that Barker’s work was valuable had offered to provide anaesthetics for him.\textsuperscript{41} He had not been put off by one of the medical objections to bonesetting that some joints with adhesions were stable tubercular joints, and breaking down the adhesions could re-activate the TB.\textsuperscript{42} In 1909 an ex-medical student, Charles Roley Thomas, fed up with his orthodox doctors, consulted Barker about his chronically stiff knee. Axham attended the case and anaesthetised him with Nitrous Oxide (which it was alleged worsened things by stiffening the musculature) whilst Barker “sweated” over breaking down the “adhesions”. The TB in Thomas’ knee was reactivated by this treatment, and after his leg was amputated by his orthodox doctors to control the disease, he successfully brought a case for damages against Barker

\textsuperscript{36} Smith, pp 887 - 943, and 973.
\textsuperscript{37} GMC, Memorandum, 71926, p. 13.
\textsuperscript{40} Paget, James, ‘Cases that bonesetters can cure’, Br. med. J., 1867, i: 1 - 4.
\textsuperscript{42} Minty, Medical Quackery, 1932, p. 90.

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in 1911. At his hearing Axham was unapologetic and stated that he would not desist from working with Barker, and continued doing so for the next 10 years (which was not difficult, since there were as yet no Dangerous Drugs Acts to prevent unregistered practitioners obtaining and using drugs like opiates).

**Bernard Shaw and the GMC**

Barker prospered despite this disaster, and was knighted in 1925, following a petition from four (registered) surgeons, Sir William Arbuthnot Lane, Sir Henry Morris, Sir Alfred Fripp, and Sir Bruce Bruce-Porter. In the wake of this triumph, according to Minty, the 82 year old Axham was "prevailed upon ... to reapply for re-admission to the Register". Minty, who was no friend of the GMC, nevertheless commented that "apart from the sentimental aspect ... the case had no merits". Since he had to reapply for his diplomas in order to be re-registered, and he was dying at the time, the situation was pathetic and "photographs in the daily press of Dr Axham anxiously awaiting his diplomas created a great deal of sympathy".

The whole business thus made a perfect public controversy, and a long correspondence in the *Times* ensued. The most prominent contributor was George Bernard Shaw who argued, hyperbolically, that the GMC must hold that the four surgeons, in associating themselves with an unqualified practitioner were "guilty of infamous professional conduct in which they were aided and abetted by the King". He claimed that the Council was "victimising" Axham because it could not act against "the King and his advisors". Furthermore, the GMC had "become a Trade Union of the worst type - in which the entry to the trade and the right to remain are at the mercy of the Union" and that it was "at the crude stage of preoccupation with earnings and sullen defiance of public opinion." He went on to call for the replacement of the Council membership with representatives of the public and the "disinterested hygienic sciences".

The debate continued for several months, and concerned not only the details and principles of Axham’s plight, but many related issues. These included the registration of osteopaths.

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43 *The Times*, 21 - 23.2.1911.
44 GMC Minutes, LXVIII, pp. 52 - 4, (24.5.11).
45 They had petitioned the Prime Minister in a letter dated 5.11.21. CEC, 31.10.22
the question of whether public or profession should decide the merits of therapy;\textsuperscript{49} the lack of appeal structure in the GMC;\textsuperscript{50} and the unrepresentative membership of the Council.\textsuperscript{51} (The correspondence quickly spilled over and blended into a concerted attack on the BMA and GMC's actions on "indirect advertising" which are dealt with in the next chapter).

Questions were asked in the House of Commons about the GMC's membership, disciplinary style and lack of appeal structure on the 3rd, 8th and 14th of December.\textsuperscript{52} Although requests for a full inquiry were refused on the grounds that no doctor had applied for one, the Privy Council promptly appointed the first a lay member of the GMC, Sir Edward Hilton Young, later Lord Kennett, in May 1926. It was denied in Parliament that this was in response to the Axham case.\textsuperscript{53}

**Reaction to the Axham case**

Moved by this storm of controversy, the Registrar of the GMC published his *Memorandum as to the constitution, functions and procedure* of the Council, which has already been discussed in Chapter 4. This document stressed that far from being a "trades union" bent on "putting down quackery", the Council was as a modest statutory body undertaking a specific task.\textsuperscript{54} What was more it required "some resolute ignoring of the signs of the times to believe that legislation restricting the practice of medicine and surgery to qualified persons is either probable or possible with us".\textsuperscript{55} James Neal writing in 1927 commented that "it was a little surprising to find medical men [so] ill-informed as to the Medical Acts and as to the constitutional position and duties of the Council."\textsuperscript{56} He defended the Council staunchly, saying that, "On the general need of action by [the GMC] against covering there cannot be two opinions, for if a man who is not qualified can practise as a doctor through association with one who is qualified, the Register ceases to protect the public against irregular practice."\textsuperscript{57}

He went on to stress its importance by saying that "any exception would frustrate the whole disciplinary procedure".\textsuperscript{58} In fact the offence, in terms of complaints to the GMC, was vanishing.

\textsuperscript{49} leader, "Dr Axham once more", *The Times*, 1.1.25, p. 13e.
\textsuperscript{50} anon, letter, *The Times*, 2.11.25, p. 15e.
\textsuperscript{51} leader, *The Times*, 26.10.25, p. 15e.
\textsuperscript{52} see *The Times*, 15.12.25, 9e.
\textsuperscript{53} *The Times*, 9.7.26, p. 10b.
\textsuperscript{54} GMC, *Memorandum*, 1926, pp. 1 - 3.
\textsuperscript{55} *ibid.*, p. 4.
\textsuperscript{56} Neal, James, 'Covering', in, [Sprigge, et al.], *Conduct of medical practice*, (1927), 1928, p. 79.
\textsuperscript{57} *ibid.*, p 180.
\textsuperscript{58} *ibid.*
Aside from 15 cases brought between 1922 and 1927 at most one case was heard each year, with only two cases being heard between 1927 and 1939. The offence of “covering” unorthodox practitioners remained as rare as it had been previously. Despite this covering and “associating with unregistered practitioners” remained in the Warning Notice, and thus in the BMA Handbooks throughout the period. Yet Neal’s views demonstrate that the “offence” rather like a charge of treason, had important significance regardless of how seldom it was committed.

The BMA investigated another doctor working for a bonesetter in 1927. Several newspaper articles in May 1927 commented on the fact that a Dr A C Marrett was planning to defy the GMC in order to act as an anaesthetist to a Mr Kennard, bone-setter of Park Crescent. By the time he appeared before the CEC in the autumn he said that he had resigned, having found things “unsuitable”. In mitigation he stated that he had only given one interview to the press, and had only taken job because little practice was available in Hastings. He promised not to cause further offence. Minty stated that the GMC was scared of taking any action against anyone connected with Barker specifically, but it is clear in this case that the threat of action before the GMC could still be effective.

From “Quacks” to “others”

There is no doubt that Shaw, in supporting Axham was furthering his own anti-medical pro-osteopathic agenda, (perhaps also seeing himself as a Hugo to Axham’s Dreyfus?). The literature is full of hints that in fashionable society at least, orthodoxy was a popular target for denigration. It was exactly this popularity of the unorthodox that had so puzzled medical writers on quackery for many years. But the traditional explanation - that the public were duped by quackery - rather implied that the public were dupes, and this patronising stance looked less and less tenable. Not only this, the cast of “irregulars” was constantly changing, and a shift in the discourse on “those other practitioners” is discernible in the early twentieth century literature.

Saundby introduced much of this ‘cast’ in 1907. He bemoaned the sympathetic attitude of the public towards “quacks” that prevented legislation being brought in. In his section on “Quacks”

59 Smith, pp 887 - 943, and 973.
60 CEC 8.11.1927.
61 see: CMAC SA BMA D141.
62 Minty, Medical Quackery, 1932, p. 35.
63 Roberts, Harry, Medical Modes and Morals, London, Michael Joseph Ltd, 1937, is particularly good example.
64 Saundby, Medical ethics, 1907, pp. 105.
he quoted advertisements at length, denounced the newspapers’ collusion and demonstrated how the public were fooled into believing that normal phenomena were symptoms of disease. He quoted the Lord Chief Justice’s definition of a quack as “a person practising medicine without a diploma”\textsuperscript{65} Despite being abortionists and fraudsters to a man (and woman), he noted that quacks were “rather popular”; a phenomenon for which he offered no explanation.

Having set up this mixture of legalistic and emotive definitions of quackery he included a wide range of practitioners in the category, warning medical men against “covering” any of them. Whilst bonesetters were an unsurprising inclusion, he went on to make a blanket condemnation of masseurs, masseuses, [medical] electricians, and radiographers, nurses offering treatment themselves or being employed as independent practitioners, and chemists who prescribed.\textsuperscript{66} Opticians who were trained in eyesight testing by the revived Spectacle Makers Company and the newly formed British Optical Association were also to be shunned.\textsuperscript{67} Saundby was condemning three things specifically (aside from advertising). First the treatment of disease independently of medical opinion and supervision, secondly the encroachment of new practitioners onto hitherto medical preserves, and lastly the assumed cheating or defrauding of patients in the process.

The discourse of public folly was again to the fore in a BMJ “Quackery” issue in 1911, which was published in the belief that “the best hope of destroying quackery is the creation and diffusion of an intellectual atmosphere in which it cannot live”.\textsuperscript{68} An editorial on “The causes of quackery” stated that its “primary cause ... is our own readiness to deceive ourselves” and traced its origins in “the early association of the art of healing with priestcraft ... wrapped in mystery”. A “third factor” was “the dishonesty of astute people who trade on the credulity of an ignorant public”.\textsuperscript{69} However, as the articles on bonesetting\textsuperscript{70} and cancer quackery\textsuperscript{71} both claimed, the profession was willing to investigate all possible techniques, but noted the reluctance of most “quacks” with the exception of Barker to share them openly. For the most part the successes of quackery could be explained by the effect of faith, belief and the fact that most of the complaints suffered or imagined would have improved anyway.

\textsuperscript{65} ibid., pp. 105 - 8.
\textsuperscript{66} ibid., pp. 70, 86, and 17.
\textsuperscript{67} ibid., p. 88.
\textsuperscript{68} Br. med. J., 1911, i: pp. 1289 - 90.
\textsuperscript{69} ibid., pp. 1290 - 2.
The distinct change in tone, and a blurring of boundaries can be seen in a lecture by Lord Dawson to the Abernethian Society of St Bartholomew’s Hospital, 26th January 1928. His subject was “those practitioners who do not give allegiance to the medical profession and are styled unqualified”. Some, he said, simply sought notoriety, whilst others had honest belief in what they did, and so they were not all quacks, since a quack defined himself by making “baseless and boastful pretensions for a method of treatment”, either deceiving himself or others. The quack may be qualified, and the unqualified practitioner might not be a quack, indeed they could be “helpful provided [their methods] are applied under the right conditions”.

How then could genuine medicine be defined and what was its role? For Dawson, diagnosis was the “rock” and “sure ground” on which to defend medicine against “false doctrine”. Diagnostic ability was the “clearly defined and exclusive province of medicine and the sciences on which it is based”, whilst on the other hand treatments could be carried out by all sorts of people. Medical ignorance of the interplay of mind and body and the role of belief in healing, on which unorthodox healers relied, were a form of incompetence. Nevertheless, he argued, “all forms of treatment should be co-ordinated and directed, through not necessarily executed, by the doctor and based on sound and accurate diagnosis.”

Thus the insistence of medical control came to the fore in this and many other discussions. For example Henry Brackenbury in his Patients and doctor, (a work which aimed to rest the therapeutic encounter on the twin pillars of scientific integrity and personal relationship,) categorised the “other practitioners” either as “trained helpers” or “unscientific healers” making a radical distinction between the two. His discussion forms a useful introduction to the last section of this chapter. For Brackenbury,

both the making of a diagnosis and the prescribing of a line of treatment are the responsibility of a doctor who has had a full medical training, and cannot with safety be entrusted to anyone else; but the actual carrying out of the prescribed treatment need not always, or even usually, be one of the doctor’s functions.

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73 (Sir) Henry Britten Brackenbury, (1866 - 1942) son of the Rev Thos. Brackenbury, was educated at Kingswood School Bath, and Westminster Hospital where he qualified in 1887. He was described by Cox as the “general practitioner[’s] stouest advocate”, who besides his work as a Hornsey GP and extensive involvement in the BMA, had made two attempts to enter Parliament as a Liberal. He served on the BMA Council from 1914, Chaired the Insurance Acts Committee from 1914 to 1924, then the ARM until 1927 and finally the Council until 1934. In 1925 he was elected to the GMC as a BMA candidate, and knighted 1932. Lancet 1942, i: 369.

Thus a midwife was essentially a “maternity nurse”, and dentists were a “great help” so long as the doctor had ultimate responsibility. By contrast, sight testing opticians and chiropodists were “anomalous” and could not be recognised for the reasons that they had “no universally accepted course of training” and were “unwilling to restrict their practice to patients sent to them by doctors as still being under their responsible care”. Turning to “unscientific healers” the central difficulty was that they claimed “the whole field of medicine as their province” whilst repudiating “the beliefs ... the methods ... of scientific medicine” using instead “theories [with no] scientific foundation whatsoever”.

Brackenbury thus placed the continuing personal responsibility of the attending practitioner, and his diagnosis, at the centre of therapeutic activity, condemning those that did not submit to this supervision, and particularly those whose practice was “unscientific”. “Other practitioners” can thus be seen to fall into distinct groups which we could characterise as the ‘controlled orthodox’, the ‘uncontrolled, but broadly orthodox’ and worst of all, the ‘uncontrolled and unorthodox’. In the next section I shall examine the way these ideas affected physiotherapists, osteopaths, and opticians, and the role of “ethics” in that process. Broadly speaking, the physiotherapists were ‘controlled orthodox’, the opticians were ‘uncontrolled, but broadly orthodox’, whilst the osteopaths were definitely ‘uncontrolled and unorthodox’. A Board of Registration of Medical Auxiliaries was organised by the BMA, Society of Apothecaries, Society of Radiographers and Chartered Society of Massage and Medical Gymnastics (see below) in 1936. Of the three groups set out above, only physiotherapists, and a tiny group of opticians belonging to the Association of Dispensing Opticians, were registered with it.

From Trained Masseuses to Physiotherapy

When Ernest Hart published his alarmist pamphlet Astounding Revelations concerning Supposed Massage Houses or Pandemoniums of Vice, Frequent by both sexes, being a complete exposé of the ways of Professed Masseurs and Masseuses, in 1895, his intention was almost certainly not to create a new profession. Massage had two reputations at the time. Some doctors, notably W S Playfair, used trained nurse masseurs to administer the Weir Mitchell system of massage, rest and

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73 *ibid.*, pp. 223 - 4.  
74 *ibid.*, p. 229.  
76 For the sake of clarity, the term “physiotherapists” (which was not coined until the 1930s) will be used when discussing therapists in this group after the First World War.
feeding for neurasthenic patients, whilst “massage” and “masseuses” were also covers for the endemic prostitution of the time. Not only did the massage business, prostitution and all, flourish after this huge publicity, but the respectable nurse-masseuses formed a Society. From the start, consistent with their background as trained nurses, these ladies used medical patronage, rules of conduct that fitted with medical wishes and clear-cut training programmes to defend and differentiate themselves from the legions of tarts and “rubbers”.  

Founded in 1894 as the Society of Trained Masseuses (a branch of the Midwives Institute and Trained Nurses Club), the Society became the Incorporated Society of Trained Masseuses in 1900. This move was prompted by financial threat of litigation by an expelled member who had broken the Society’s rule on advertising outside the medical press. In 1920, having had a ‘good war’ treating the wounded, a Royal Charter was granted creating the Chartered Society of Massage and Medical Gymnastics (CSMMG). This name was felt to be inappropriate and inaccurate by the 1930s and it was changed to the Chartered Society of Physiotherapists in 1944. The rules of the original Society were never altered in essence although they became bye-laws in 1929. They stipulated that members should give no massage without medical supervision, and submit no advertising to any but strictly medical papers. These strictures, along with the patronage of eminent medical men such as W S Playfair, Sir Frederick Treves, Sir Edwin Cooper Perry, and Sir Thomas Horder were vital to their acceptance by the medical profession.  

This professional strategy involved physiotherapists in a set of “binds”. They faced competition from “unqualified ‘rubbers’, bath attendants, men who carried out a little electrical treatment after work” as well as doctors with electrotherapeutic and actinotherapeutic equipment. Many doctors were content to use poorly trained physical therapists and until state registration was achieved in 1962 the small proportion of physiotherapists in private practice were caught between the diversification and advertising necessary for survival, and the strict rules of the Society that forbade this. Thus “self-advertisement, beauty work, and working without medical advice were regularly reported”. Rather than slacken off, the Council responded by turning “the informal rules into binding ethical bye-laws”. Things came to a head in 1928 - 9 in a debate in which some voiced their frustration at losing patients to unqualified advertisers, the inconvenience of doctor’s

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80 ibid., pp. 26 - 31. Horder and Perry both served as Presidents of the CSMMG.
81 ibid., p. xv.
82 Shaw, George Bernard, ‘Doctors and the Public’ (letter), The Times, 12.11.1925, 10a.
83 Barclay, In good hands, 1994, p. 78.
recommendations, and “being robbed of work by doctors with ultraviolet lamps” and so forth. But the argument that the rules prevented them from being “a society of trained quacks and money-grubbers” won the day.  

**Osteopathy**

Bonesetting and osteopathy were often confused in public discussion, and both were popular. Osteopathy was a system of healing devised by an American “founding father”, Andrew Taylor Still. It was grouped by Brakenbury along with other “healing cults” (including chiropractors, naturopaths and Christian Science healers,) that were characteristically introduced to Britain from the USA. Still, who had lost three children to spinal meningitis in the 1860s, combined bonesetting, animal magnetism and mesmerism to evolve a set of ideas and practices focused around the “osteopathic spinal lesion”. Osteopaths used spinal manipulation to influence the health not only of the back, but of the whole body, and Osteopathy had established itself as a rival profession to medicine in the USA. The American Osteopathic Association was founded in 1897 and had numerous colleges associated with it. British osteopathy on the other hand remained poorly organised for many years, although the claims made for it were in no way diminished.

Some physiotherapists (and indeed a handful of doctors) became interested in and trained in osteopathy as it became established in Britain from the 1920s onwards. But osteopaths contrasted with physiotherapists in nearly every respect. Osteopaths offered themselves as practitioners of a complete medical system around an unvarying set of therapeutic tools, never accepted medical supervision, or the strictures of a quasi-medical ethical code, and pushed hard, and comparatively early, for state registration. Unsurprisingly their attempts at registration were opposed by the medical profession and therefore by the CSMMG. Osteopaths may have faced hostility from a profession they claimed equality with, but at least they were not hamstrung as physiotherapists were by an ethical code designed entirely to please doctors, who in turn failed to recommend, employ or even at times recognise them.

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84 *ibid.*, pp. 77 - 79.
88 Barclay, *In good hands*, 1994, pp. 104 - 5. Barclay states there were 1400 osteopaths in Britain in the 1930s.
89 *ibid.*, p. 88 - 90.
90 *ibid.*, p. 105.
Another difference was the high public profile and popularity of osteopathy. Hill and Clegg, in contrast to earlier discourses on the unorthodox, presented a carefully thought out argument for this, along with a description of the unpopularity of medicine, in their book *What is osteopathy*? They pointed out that,

The non-medical public is always ready to criticise the medical profession. While the individual has, in most cases a profound respect for the doctor of his choice the public as a whole is suspicious of doctors in the mass. It charges them with hindering the advancement of knowledge ... it suspects there is some truth in Bernard Shaw’s gibe that medical men have a vested interest in ill-health and are therefore reluctant to encourage ... good health. The BMA ... has been accused by cynics of being nothing more than a trade union. ... The public resents too the attempts of the medical profession to keep its own house in order, despite the fact that the primary purpose of these efforts is the safeguarding of the interests of the public. It criticizes the GMC for enforcing standards agreed upon and accepted by the profession ... for the protection of the public.\(^{92}\)

They went on,

In becoming more a science and less of an art medicine has inevitably lost some of its mystery and magic. The doctor has become less of a medicine man and more of a skilled technician. He no longer claims to be infallible; and the sick person looks, naturally but unreasonably, for infallibility in his healer. For the patient, bedside manners have become corrupted by communications from the laboratory.\(^{93}\)

Thus the osteopath’s dogmatism and their freedom from the laboratory were perfectly matched to a need that Hill and Clegg perceived in the popular imagination. Strikingly, when they came to a discussion of anaesthetists and osteopaths, they stated quite categorically that the issue was not collaboration, but responsibility; “[where] the registered medical practitioner assumes a responsibility for the diagnosis and the treatment ... no question of action by the GMC can arise”.\(^{94}\)

This may well represent a shift in attitudes consequent on the recognition of the importance of public opinion. (See pp 199 - 202 in Chapter 9) Thus in le Fleming’s book on general practice, a

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\(^{91}\) Charles Hill, (Lord Hill of Luton) (1904 - 1989) led an extraordinary career having been educated at St. Olave’s School London, Trinity College Cambridge, and the London Hospital. After a short spell in practice he became first Deputy Medical Secretary then Medical Secretary of the BMA in 1944. In this role he took on Nye Bevan over the inception of the NHS. From his success as “Radio Doctor” he entered Parliament as a Conservative, rising eventually to McMillan’s cabinet, whilst his administrative skills were used as head of the ITA 1963 - 7, and then chair of Governors of the BBC 1967 - 72, and finally as chairman of Abbey National and Laporte Industries.


three page section discussing doctors relations with unqualified practitioners advised tolerating the patient’s views and did not mention “covering” at all.\textsuperscript{95}

\textbf{Opticians}

The forerunners of today’s professionalised commercial opticians were traders in refracting devices and other goods such as jewellery and electrical equipment, ranging from highly skilled workers to street hawkers.\textsuperscript{96} In the 1890s opticians were beginning to organise. The British Optical Association was formed in 1895, partly in response to a BMA sponsored Bill to restrict the use of the terms “ophthalmic” and “occulist” to registered medical practitioners, and quickly organised training and qualification structures. The hitherto vestigial Corporation, the Spectacle Makers Company also responded with training courses and examinations.\textsuperscript{97} A third body, the Institute of Ophthalmic Opticians was formed in 1905 to be an equivalent of the BMA for opticians. The BMA opposed this development of eyesight testing by a group of tradesmen stating that “sight-testing” by such trained opticians was “fraught with special risk to the public”.\textsuperscript{98} The BMA were to keep up this critique of eyesight testing as dangerous unless undertaken by a medical practitioner for the next 3 decades.

Discussing the differences between the SMC and the BOA, Saundby noted that the SMC forbade advertising that implied opticians had medical qualifications. The BOA on the other hand was “more aggressive”. It trained opticians in eye-sight testing, but they were in a dilemma. Either they could not treat patients, or they would need to use drugs like atropine. Medical practitioners, he said, should not “cover” these opticians by instilling atropine for them, and neither should doctors take part in examining the opticians for their diplomas in eyesight testing.\textsuperscript{99}

The problems facing opticians in their struggle for medical and state recognition were their trading status, the need to be able to answer medical charges of “danger” involved in lay eyesight testing, and the struggles and differences between the various bodies, particularly the SMC and BOA. The IOO for instance adopted a set of by-laws which forbade members from advertising in a way which

\textsuperscript{95} Le Fleming, E Kaye, \textit{An Introduction to General Practice}, London, Edward Arnold, 1936, pp. 101 - 3.


\textsuperscript{97} Minty, \textit{Medical Quackery}, 1932.

\textsuperscript{98} Report of MPC, ARM 1904.

\textsuperscript{99} Saundby, \textit{Medical ethics}, p. 88. In fact by the late 1930s a member of the GMC was actually involved in training and examining opticians. see letter, John D’Ewart 24.4.1937, CMAC SA BMA D97.
harmed other “fellow-craftsmen”, from using the Institute’s diplomas or certificates to masquerade as medical qualifications in advertising, or from displaying them anywhere except premises actually used for the purposes. However, these by-laws did not include a stipulation to only undertake testing under medical supervision.\textsuperscript{100} BMA evidence to the Departmental Committee on the Causes and Prevention of Blindness in 1922 stressed the “danger” in letting opticians see patients themselves, and the Royal Commission on National Health Insurance, 1926 recommended that it was best to see an eye specialist rather than an optician in the first instance.\textsuperscript{101} An Optical Practitioners (Registration) Bill failed in 1927 because of the disorganisation and variable standards of opticians.\textsuperscript{102}

The BOA was, in the meantime, attempting to maintain a distinction between their members and tradesmen and itinerant eyesight testers. Advertising was seen as a key issue, since it could not practically be banned, but was evidently open to abuses in terms of claims made. The BOA issued “A code of ethics” in 1932 that recognised this but instructed members to desist from advertising free tests, discounts, special lenses to “affect bodily health”, personal superiority, and other commercial goods. This code was strengthened and made more specific in 1934. Opticians were eventually registered under a private members’ Bill in 1958.\textsuperscript{103}

\textbf{Discussion}

Despite the wide range of material pulled together in this chapter, I should like to point out a set of social and professional trends that were shot through and often frankly negotiated with reference to moral categories, ideals and codes of ethics. The medical marketplace of early twentieth century Britain was still crowded and heterogeneous, but differed from that evoked in Porter’s work in the vital respect that practitioners now primarily identified themselves as members of distinct groups rather than as individuals. Those belonging to the orthodox medical profession (who had a “lead” on statutory status that has never really been lost) saw themselves as constituting the most important group, with the widest expertise and knowledge. Efforts were made to “tidy” the edges of the group in respect of homeopaths and of unqualified assistants. In the case of homeopathy, the ambiguous boundaries were left undisturbed in an uneasy truce, but ethical ideas were used to provide justification for those who chose to make life difficult for these practitioners. The unqualified

\textsuperscript{100} Minty, \textit{Medical Quackery}, 1932, p. 171.  
\textsuperscript{101} Brackenbury, \textit{Doctor and patient}, 1935, pp. 223 - 4 and 229.  
\textsuperscript{103} \textit{ibid}, pp. 148 - 150.
assistants eventually succumbed to a combination of the campaign against contract practice and the logic of the GMC's statutory role.

The disciplinary offence invented to bring this about, “covering”, was quickly adapted in such a way as to make any interaction with an unregistered practitioner that was not self-evidently supervisory a grounds for expulsion from the registered profession. Yet there were influential voices in the public discourse of the early 1920s who chose to see this as one of a number of abuses of professional power. The GMC was attacked for its role in the Axham case, an attack which brought about the introduction of the first lay member on the Council in its 70 year history. The weakness in the orthodox profession’s position was its unpopularity among influential people and the popularity of other practices, in particular osteopathy. Doctors, who liked to style their opponents as “sects” and “cults”, were attacked as belonging to an interest group with its own curious code of conduct which was designed simply to protect its own interest. At the same time the medical discourse on “other practitioners” had been changing. Blanket condemnation, and the blaming of public gullibility, last evident in Saundby’s book and the BMJ’s Quackery issue, were replaced by a more nuanced discussion that acknowledged the faults of orthodoxy, and differentiated between various shades of “otherness”, strongly favouring those that offered themselves as subjects to medical hegemony. It is also striking that apologists for the medical profession began to use the rhetoric of scientific detachment and self-criticism to distinguish themselves from these competing “cults”.

These groups of “others” themselves adopted different strategies of professionalisation that were reflected in their codes of ethics. Thus physiotherapists banned both advertising and independent practice, and suffered for it, osteopaths banned nothing and defied medicine outright, and opticians whilst attempting to boost their status by moderating advertising did not, by and large encode for medical supervision. In the following chapters I shall set out the ethics of advertising for doctors.
Chapter 9

Advertising and the individual doctor

An introductory history of advertising and professional attitudes

Introduction

Advertising is integral to the free market economy. It provides information (and disinformation) about goods and services, and seeks to establish the greatest possible market share for each advertiser's own product. Advertising by doctors has also been a disciplinary issue, and effectively 'banned' in Britain for most of this century. (The GMC issued its first written condemnation of advertising in 1899;\(^1\) in 1989 the Monopolies and Mergers Commission decided that the restrictions placed on advertising by the GMC operated against the public interest.\(^2\)) It was seen as inimical to the nature of medical professionalism, damaging to the profession's social status, opposed to the ideal of disinterested success, and vital in distinguishing legitimate practitioners from tradesmen and quacks. Advertising, (whether deliberate, inadvertent or simply perceived by sensitive colleagues), was a constant problem. For those selling medicines, or running clinics and other commercial medical ventures the problem was even more acute. Many in this market were not doctors, and even for medical practitioners, total abstinence from advertising was out of the question. But the involvement of named doctors, the health and cultural effects of these goods and services, and their impact on the referral relationships between practitioners made ethical debates about such advertising inevitable.

Advertising is perhaps the most ubiquitous theme in the CEC archive material, and remained a 'core' concern during the whole of the period studied. Its ubiquity is problematic. A single integrated account of all the issues, cases and comments in which it featured, even for this one organisation over this short time period, would run to many tens of thousands of words. I have therefore limited the material discussed as far as possible, and have made a distinction between two broad categories of advertising material, allocating each its own chapter.

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\(^1\) GMC, Minutes, 1899, XXVI, p. 275.
The first, after covering the general history of the subject, examines the advertising of the individual practitioner, that is advertising that was construed as “attracting patients” to a particular doctor. This was simple in essence, but numerous different forms of varying directness were encountered. The central furore on individual advertising centred on signed contributions in the lay press, but I will include in this chapter a discussion of the question of doorplates and other notices. The second chapter concerns the more specific commercial aspects of medicine, in which the advertisement of treatments and facilities, secret remedies, medicines, “hydros”, nursing homes and clinics was contentious. The issues of profiting from a medical technology through patents, and the problem of secret remedies, are also included. In this second chapter two broad issues emerge, the questionable propriety of an interest in something which you might recommend to your own patients, and the disruption of ‘normal’ relationships between doctors and patients created by commercialised medicine.

The free press and the free market in medicine

The histories of advertising, quackery, nostrum peddling, and the Press are inextricably linked. The first newsheets that appeared in the seventeenth century made no great distinction between advertisements - information placed for public attention in return for a fee - and the rest of their copy. *The Times* continued to carry advertisements rather than news on its front page until the late twentieth century. The reliance of such 18th century publications as *Tatler* and *Spectator* on advertisers was a weakness exploited by an aggressive flat-rate tax on advertisements introduced in the reign of Queen Anne, that caused many of them to fold. Another effect of the tax was to drive the small trader and ordinary lay-man out of advertising, whilst offering “no restraint to the sharpers”. Since chief amongst these were nostrum vendors and sick trade showmen, the ‘free press’ and the free market in cures were interdependent from this very early stage.

Thomas Beddoes, writing around the turn of the eighteenth century saw many doctors as no better than quacks, serving “Plutus” rather than “Hygeia”. The Georgian market in health care was a hurly-burly affair, in which practitioners of all shades and types competed openly, using much the same methods, for patronage and fees. Charles Cowan’s report on Empiricism, read to the PMSA
1840 stressed that many ‘regulars’ were involved in quack medicines. Generally, it was said, “cheating advertisements of pills, ointments and nasty books” were not regarded by the profession “with the abhorrence which they deserve”7 During the early to mid-nineteenth century several leading proprietary medicine manufacturers started to advertise systematically, including some medically qualified men. It was said that anyone with £10,000 in capital to spend on advertising, could not fail to make a fortune.8 One doctor, James Morison sold a “Universal Pill” and supported a large staff of “Hygeians”. Thomas Holloway’s Pills and Ointment and later, in the 1860s, Beecham’s Pills were to sweep the country, and earning vast profits on the back of huge advertising campaigns. In addition to these ‘big fish’ many advertised remedies at this period, and well into the twentieth century, were either abortifacients (“Lady Montrose’s Miracle Female Tabule”) or were put forward as cures for venereal disease.9 Testimonials, which were frequently paid for, and thus supported several impecunious European aristocrats, were another common feature of such proprietary medicine advertising.

Medical Reformers were not alone in their distaste. Mid-Victorian businessmen often felt that advertising was beneath them, and Turner’s account of their ideal is very close to the medical ideal of success in practice, indeed, it would accurately describe if the specific terms were substituted. He said,

All but a few manufacturers ... were quite convinced that [advertising] was ungentlemanly. Some may even have agreed with Carlyle that it was against nature. The ideal, the traditional way to do business was to surround oneself with a circle of customers and to cultivate personal relations with them; excellence of goods, and word-of-mouth recommendation would do the rest ...[rather than enter the] ... contaminating company of truss-mongers, snuff sellers, pox doctors, body snatching undertakers and cut-price abortionists.10

However the economics of complex mass production increasingly drove firms to devote large budgets to vigorous advertising campaigns.

The punitive advertising tax was lifted in 1853, shortly followed by the abolition of stamp duty on newspapers (1855) and the lifting of tax on paper (1861) and the daily press was to expanded

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10 ibid., p. 83.
enormously once these handicaps had been removed. However spending on innovations such as the populist journalism instigated by Harmsworth’s Daily Mail and the extensive correspondence system of The Times, easily kept pace with revenues. The press continued to rely on advertising and the “gentlemen of the press” continued to find their association with it embarrassing. By the late 19th century there was not only the matter of the “pox-doctors ... and abortionists” but the general ubiquity of advertising, particularly by larger companies, seemed to be cheapening the whole of national life, and widespread reaction against it had set in by the turn of the century.

Regulation, and the emergence of advertising ethics

Advertising men themselves began to put their house in order in response to the criticisms that advertising was debasing and inaccurate. Bishop’s comments on the rise of regulation and ethics in advertising can, like Turner’s quoted earlier, be seen as a neatly analogous account to the shifts that were occurring in medicine. “The faults of commercial advertising”, he said, were “glaring and obvious”, but, as in the case of football, it was possible to get the rules of the game clearly defined, and to ensure that the spirit in which it should be played becomes part of the mental make up of the players. Football began as a glorious ‘free-for-all in which whole villages took part and in which many bones were broken. Commercial advertising began in much the same spirit, and will in time, it seems reasonable to hope, achieve as firm a code of behaviour, and as high a degree of restraint and discipline, as football has developed. ... Given a proper code of conduct an advertiser would be rightly condemned if he violated it either in the spirit or the letter.

The Advertisers’ Protection Society, later renamed the Incorporated Society of British Advertisers, was formed in 1900 largely to campaign for the publication of circulation figures. They also concerned themselves with “ethics”, particularly of “truthfulness” and “knocking copy” (running down the opposition). There were also legislative curbs. The 1889 Indecent Advertisements Act banned advertising relating to VD cures and other sexual problems, but did little more than force on a fresh crop of euphemisms. The 1917 VD Act made any advertisement for VD cures or for unregistered practitioners offering treatment illegal. This “disease category” model was not extended until the 1939 Cancer Act that banned advertisements claiming cancer cures, and the 1941 Pharmacy and Medicines Act, which banned any advertising that claimed to offer a cure for a whole

13 Bishop, Ethics of advertising, 1949, p. 52.
14 Turner, Shocking History, 1952, pp. 143 - 168
series of serious chronic complaints. This latter proposal had first been put forward by the Royal Commission on Patent Medicines on the day that the Great War broke out in 1914, and was therefore lost to the parliamentary process. The Commission had been set up in the wake of the BMA’s Secret Remedies campaign (described in more detail in the following chapter) and pressure from bodies such as the Temperance movement, and publications like the *Woman’s Home Journal*. In addition to alarm (shared by all these groups) at the fact that many proprietary medicines were addictive, containing high strength alcohol, cocaine, opium and hemp, the BMA emphasised that these medications were either of worthless, dangerous, or both, and prevented patients from presenting appropriately to their doctor.

In the long pause between the Royal Commission and the Pharmacy Act advertisers began to introduce self-regulation and ethical codes. From 1926 the Advertising Association undertook to investigate abuses of advertising, brought to their attention by advertising managers, and also condemned the use of paid testimonials. The BMA and Proprietary Association co-operated with the Advertising Association to produce a report that, in line with the Royal Commission, recommended the rejection of advertising copy that claimed cures for cancer, consumption, rupture, diabetes, epilepsy and rheumatoid arthritis. This type of “voluntary censorship” started in earnest in 1928. Generally speaking, advertising was still seen as a social threat by many in the interwar period. It was held to undermine society and individual integrity by encouraging materialism, appealing to base instincts like fear rather than to reason, and through its untruthful claims.

Writing in 1952, Turner pointed out that “the public at large little suspects the extent to which advertising has been made ‘respectable’ in the last dozen or so years”.

**Advertising and Medical Ethics in the Nineteenth century**

Given that they were contemporaries, it is striking that the various modes of attention seeking and quackery in medicine that Beddoes railed against were not discussed in Percival’s *Medical Ethics*. Whilst his approval seems highly unlikely, we can note that his code dealt almost exclusively with the relations between individuals with contractual and moral obligations to each other, and with the State. Percival was interested in the situation in which doctor and patient were already in relation to one another, and although he warns against criticising other doctors, he has almost nothing to say

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15 *ibid.*, p. 169.
16 Bishop, p. 114
17 *ibid.*, pp. 106 - 7
18 *ibid.*, p. 16
about how they came to be doctor and patient to each other. He had far more to say on the subject of secret remedies, nostrums or proprietary medicines, but did not object to them on the grounds of advertising. Whilst allowing tolerance of the patient's foibles and fads, so long as they were not harmful, he condemned the medical exploitation of a secret nostrum as "disgraceful to the profession" and stated that such exploitation could only be actuated by "either disgraceful ignorance or fraudulent avarice". This stance was consistent with one of the main aims of his book, the promotion of information sharing and learned communication between doctors. Keeping a useful treatment hidden from fellow members of "the faculty" was inconsistent with "beneficence and professional liberality".

De Styrap roundly condemned medical advertising in a huge sentence that ran to over a page of text. The passage is worth quoting intact, in spite of the difficult nature of the prose, for the insight it affords into Victorian medical objections to advertising. Thus, he said,

It is degrading to the true science of medicine to practise homoeopathy, or professedly or exclusively, hydropathy or mesmerism; and alike derogatory to the profession to solicit practice by advertisement, card or printed circular, or to notify change of residence, the introduction and address of a partner, or the transfer of a practice, otherwise than viva voce, or by an autographic of other fac-simile of a written note, and its circulation strictly limited to bona fide patients of the transmitter; also to offer by public announcements gratuitous advice to the poor, or to promise radical cures; to publish cases and operations, or semi-medical articles with the name and professional suffix of the writer appended thereto, in the lay press, or, knowingly, to suffer such publications to be made or otherwise issued to the public; to "tender" for a club or other paid appointment, or to apply or canvass for such ere a vacancy has been declared; to advertise medical works in non-medical papers, or to contribute articles on professional subjects to journals professing to furnish the general public with medical information and advice in relation to disease, or in any way to advertise or permit himself to be advertised therein; 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.

What can we deduce from this list? Firstly all the activities he condemns smack of charlatanry. All the activities are basically designed to attract attention to the doctor by making him appear special, distinctive or simply cheap. Retrospective comments by Squire Sprigge to the effect that even reading in church had during this period been frowned upon suggest that any attempt to attract attention was considered by late 19th century medical moralists to be unprofessional. (Not that one can imagine the pious de Styrap baulking at an opportunity to preach.) Although de Styrap didn't

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20 Percival, Medical Ethics 1803, II.xxi - ii.
21 de Styrap, Medical Ethics, 1890, p. 49.
use the words mountebank or quack here, these words both refer to attempts to attract the attention of the crowd, by climbing on a bench, or by making a noise. The root of the word advertising means “turning towards” and so the whole linguistic and ethical construct is based on the same basic idea. The ethical medical man should thus rely on reputation alone to attract patients, and even then, there were scrupulous rules to be observed in taking over the patients of other doctors. De Stypa’s list left out very few of the categories of advertising and its variants with which the CEC were still dealing in the 1920s and 1930s.

The Resolutions and bye-laws of the RCP contained ideas that reinforce this Victorian consensus. In 1873 the College resolved that the advertising of books by medical authors in non-medical journals “especially with the addition of laudatory extracts from reviews, is not only derogatory to the authors themselves, but it is also injurious to the higher interests of the Profession”.

We have already examined the Resolution of 1881 that forbade members to “trade on” “special designations”. The College later stated that advertising medical works, and “laudatory certificates” (testimonials) for preparations and appliances was “misleading to the public, derogatory to the dignity of the profession, and contrary to the traditions and resolutions of the RCP”. At the same time, the College resolved that articles on “Medical Subjects” for “journals professing to supply medical knowledge to the general public” were “undesirable”, and members were not to write for such publications. The College also had a bye-law relating to secret remedies, although, being a College bye-law, it was remarkably inward looking, and was linked to the College’s ancient function as the compiler of the London Pharmacopoeia. It stipulated that no member should “refuse to make known [to the Censors]... the nature and composition of any remedy he uses”.

The overcrowded marketplace

Thus nineteenth century doctors, especially physicians, were enjoined to be conspicuously inconspicuous in the medical marketplace, to distinguish themselves by not distinguishing themselves from their professional brethren, and to allow a free discourse on treatment and ideas to flow within their ranks whilst carefully excluding all others from this knowledge. Yet as the century progressed these ideas were pressed into service by a profession that appeared in many areas to be grossly overcrowded. The second BMA Section of Ethics in 1896 discussed the

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23 RCP(L), The Charter, Bye-laws and Regulations ..., 1933. (Resolution of 9.6.1873)
24 ibid., (Resolution of 2.2.1888).
25 ibid., (Resolution of 27.7.1882).
26 ibid., (Resolution of 2.2.1888).
27 RCP(L), The Charter, Bye-laws and Regulations, 1862, Bye-law XXIII vi
problem, which all speakers agreed were lowering the moral tone, public standing and material wellbeing of the profession. The suggested remedies were to limit the numbers of medical students through “arts” and physical examinations, raising the age of entry to medical school and the suppression of cheap club practice. Sprigge, writing in 1905, was keen to play down the problem, employing statistics to demonstrate an “inherently good” ratio of doctors to general population, (1:1271 in 1861 and 1:1133 in 1904) but even he had to admit that “here and there the stress of competition tells, and tells forcibly…” Whether or not the issue was numerical or behavioural, competition was evidently a problem. The first *Handbook for Newly Qualified Practitioners* referred to “a condition of matters now happily disappearing, [in which] members of the profession regarded themselves simply and solely as rivals”.

That advertising was linked to competition, and competition to overcrowding is borne out by the fact that complaints of advertising to the GMC ran at a remarkably constant rate in the first half of the twentieth century. The exception was during the Great War, when enormous numbers of doctors were transferred to military service, and during which time patients were effectively barred from changing doctors. I have abstracted the following figures from Smith’s index.

*Table 11: numbers of practitioners investigated and erased from the Register for advertising offences between 1900 and 1935.*

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<td>1930 - 34</td>
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31 CEC, 8.6.1917.
Getting advertising noticed: the BMA and the GMC, 1905

Although the GMC’s Report on Medical Aid Societies of 1899 was clear on the unethical status of advertising, the BMA was to find some difficulty enforcing it as an ethical rule. Of the four cases which the CEC brought to the attention of the GMC in the session 1904 - 05, three had concerned advertising and canvassing. One doctor, involved in a provident Dispensary, had already been before the GMC for advertising, whilst another, circulating handbills, claimed ignorance of the GMC’s warning on canvassing. There had been many other cases where practitioners had claimed ignorance of the 1899 ruling. The number of cases of advertising and canvassing being brought to the attention of the CEC, and the link with contract practice were both factors in the decision by Council to approach the GMC for clearer guidance on the question.

Andrew Clark (the Chair of Council), Saundby and Smith Whittaker wrote to Donald MacAlister, the President of the GMC in June 1905. They outlined the difficulty in prosecuting cases of canvassing and advertising where the practitioner claimed not to be aware “that there was any professional objection” to such activities. The letter went on to propose that “advertising, including canvassing, by medical practitioners for the purpose of procuring patients is injurious to the interests of the public as well as of the medical profession”, (although no evidence was adduced to support either of these claims) and ought to come under Section 29 of 1858 Act. They therefore asked the GMC to declare “disapproval of systematic canvassing and advertising for the purpose of procuring patients, by cards, handbills, newspaper notices or other means”. They acknowledged that although the GMC had no statutory power to create bye-laws to regulate the profession, their resolutions of 1897 and 1899 had “been of great benefit”, and had established a “precedent”. The issue of “such a notice” would help those in ignorance and deprive deliberate offenders of their excuse.

Victor Horsley supported this application when it came before the GMC, and the executive committee and counsel were asked to consider the matter. Counsel felt that the notice was allowable, but noted that it shifted the Council’s sphere of influence. He also warned the notice would beg the question of whether “every kind of advertisement” was to be suppressed. If this was so, he said, “the grounds upon which it might be deemed ‘infamous conduct in a professional

33 BMA, Yearbook 1906, pp. 80 - 82.
34 Council, 18.1.1905.
35 Appendix A, CEC, 16.06.1905.
36 GMC, Minutes, 1905 XLII: (27.5.1905) p. 84.
The notice adopted by the GMC in December 1905 did set out some such reasons. It stated that

some medical practitioners have with a view to their own gain and to the detriment of other practitioners been in the habit of issuing or sanctioning the issue of advertisements of an objectionable character. The practice of (a) advertising by a registered medical practitioner with a view to his own gain, particularly if deprecatory of other practitioners, or of sanctioning such advertising, of (b) employing or sanctioning the employment of agents or canvassers for the purpose of procuring patients and of (c) associating with or accepting employment under any Association which practises canvassing or advertising for the purpose of procuring patients are ... contrary to the public interest and discreditable to the profession of medicine and any registered medical practitioner resorting to any such practices renders himself liable .... to have his name erased from the Medical Register.\(^38\)

The BMA was able in the years that followed to use this "statutory ban" as a key weapon in its efforts to suppress medical advertising in all its forms, but never mentioned its own part in its forging.

In the period after 1905 the CEC included all sorts of advertising in its 'working definition' of the offence, effectively using the GMC's Notice to frame the offences listed by de Styrap and the RCP. These included the publication of named interviews, named articles, addresses, and photographs. Books on medical matters could give the author's name, but not address, and advertising for these books could make no claims on behalf of the book or its author. More explicit forms of advertising had been censured, including the placing of change of address notices in papers.\(^39\)

**Success and Virtue**

Although writers on medical ethics after 1899 and 1905 could simply point to the GMC's rulings as an absolute condemnation, all these works, and also the deliberations and statements of the BMA show a clear preference for trying to explain it as a matter of principle. Indeed it was frequently used as a rhetorical exposition of medical professionalism and virtues.

Saundby, writing in 1907, stated "the only advertisement to the public which is now permitted is the doorplate, which should be of modest size". He continued his advice (a précis of the CEC's rulings on the subject in the early 1900s) by setting out further restrictions. A plate could state that the

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\(^{38}\) *ibid.*, p. 139, (1.12.1905).

\(^{39}\) A memorandum in CMAC SA BMA D235 lists: CEC, min 19 1904, CEC, min 89 1910, CEC, min 29 1918, CEC, min 29 1908 to support each of these decisions.
practitioner was a surgeon, or physician, but could state no speciality. The window of a building could bear the legend “SURGERY” but should on no account display a scale of fees. No plates were to be displayed on any building where the doctor did not actually practice. With de Styrap, he ruled that circulars were to be sent to bona fide patients only, and posters and handbills advertising lectures were disallowed; even a lecture itself might be “unsuitable” in style or content.\(^{40}\)

Saundby explained that the commonplace medical objection to unfair advantage through advertisement was “superficial”. The matter went deeper than that. He cited a recent law case to demonstrate the deceptive nature of the low art. The proprietors of “Bile Beans” had sued a rival firm marketing a brand of bile beans but in Court their advertising claims were exposed as pure hokum\(^{41}\). “If medical practitioners advertised,” Saundby argued, “the public would be as little able to discriminate the value of their claims as they are now able to form an opinion as to the real worth of bile beans”, and if advertising were pursued then the “scientific worker would be elbowed out”.\(^{42}\)

By contrast, the stress on “unfair competition” meant that complaints of advertising were “all too often based upon trifles ... this would be ridiculous if it were not too evidently the outcome of odium medicum, a failing [which] is a source of weakness to the profession.”\(^{43}\) Thus Saundby was attempting to raise the tone of the objection above simple jealousy and competitiveness.

Aitchison Robertson commented on advertising in his chapters on “Success in Practice” and “Increasing your practice”, in which he advised his readers how best to start out and obtain patients. Robertson’s approach was to define an ideal. The keys to success were promptness; especially with new patients and emergencies, manner; avoiding both argumentitiveness and servility, secrecy and tact, and courtesy to all. Armed with such virtues “your practice will extend itself without any direct effort on your part”.\(^{44}\) Thus adding your qualifications to your doorplate would not help, since they were not indicators of quality or experience.\(^{45}\) A medical practice, he said, increased mainly by influx of new patients into an area, and new patients should only come by recommendation, not by any other means, and certainly no means that smacked of commercialism.\(^{46}\) The doctor, doing as he would be done by, should never “sink to the methods of competitors”.\(^{47}\)

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\(^{41}\) Second court of sessions, Edinburgh, 20.7.1906

\(^{42}\) Saundby, *Medical ethics*, 1907, p. 3.

\(^{43}\) ibid., pp. 4 - 6.

\(^{44}\) Robertson, *Medical Conduct and Practice*, 1921, p. 43.

\(^{45}\) ibid., pp. 32 - 33.

\(^{46}\) ibid., p. 51
This sort of ideal appears to be in the minds of many doctors when discussing the question of advertising; Squire Sprigge's discussion combined the "untestable claims", and the "unfair competition" arguments with the idealistic. Thus whilst his discussion rehearsed ideas that had been in currency for nearly a century, he was writing after the embarrassing events of 1925-27 (which are dealt with below) and so he had added a much clearer appeal to the public interest. The "correct professional ... spirit", he said,

mark[s] the distinction ... between those who are working on commercial lines, and those who are following a learned calling. ... [and] is usually defined by one simple example ...

Thus it is correct for individuals or firms to advertise to the public that they sell something which is better or cheaper (or both) than any similar goods sold by any other individuals or firms, for the public can try out the claims. But it is wrong for a doctor to convey to the public that he possesses a method of therapeutics that is better or cheaper (or both) than any method possessed by his fellow practitioners, if only because the public cannot sift the evidence for the claims. ... the public can never tell how far any particular treatment has dealt adequately with the whole case, or, indeed, what the whole case is. ... It is among fellow practitioners that any claim for therapeutic success should be made, because they are in a position to understand the arguments and check the results .... The impropriety of direct public appeal by doctors consists in the real risk to public safety. Those who vaunt their own merits, while gaining prestige at the expense of their fellows (and breaking the Gospel rule) are impeding the cause of medicine, and that is the thing that matters. In every question of medical ethics it is necessary to bear in mind the public weal, and also the privileges of a calling whose followers are united to promote that public weal by the advancement of scientific knowledge.48

These attitudes were neatly summed up in the BMA Handbook for Newly Qualified Medical Practitioners of 1926 which stated,

no medical practitioner should attempt in any way to advertise himself or to gain reputation except by the legitimate means of proficiency in his work and by skill and success in the practice of his profession. ... The word advertising in relation to the medical profession must be taken in its broadest sense.49

47 ibid., pp. 74 - 75
Indirect Methods of Advertising

The material indicated between \% marks also appeared in my 1994 paper, “The medical pundits”, (in appendix B). Here it has been abridged, and footnotes have been kept to a minimum.

Whilst the practice of attracting attention indirectly through signed articles and other features in the press had been condemned for many years it didn’t become really problematic for the CEC until after the Great War. That it became so was partly due to a rising editorial, if not popular, demand for health educational and other quasi-medical pieces in the daily press. Lord Northcliffe had also advised his staff, “Get more names in the paper - the more aristocratic the better”. It became particularly difficult to take a firm line on the issue once elite practitioners became routinely involved in such journalism. When a famous medical baronet instituted a concerted campaign of health education by these means, in deliberate defiance of the BMA, the Association’s position became almost impossible.

The GMC approached again

Anderson wrote a memorandum for the CEC on the subject in early 1922. The problem had been increasing over the previous 2 or 3 years, and the CEC was “frequently” receiving complaints about articles, books, notices and pamphlets. The problem was that doctors of “high standing” were appearing so often as authors, described in glowing terms as “specialists” or “experts”, that the principle of non-advertisement was effectively being breached. Whilst it was felt that many cases could be settled “by an appeal to good taste” it also seemed important to request that the GMC broaden its Warning Notice so that all such activities were explicitly included.

The Association had already approached the GMC through the Direct Representatives bringing to their attention a number of articles and pointing out that the CEC was trying to uphold the spirit of the Warning Notice, but the high standing of the offenders made it difficult for them to proceed. Robert Bolam had reported back that the GMC would prefer to investigate a definite case, rather than issue a statement. However, one of their difficulties was the fact that the Association would

51 Memorandum, CEC, 15.2.1922.
52 “St. Thomas’s Hospital and the Men and Women who direct it”, Sphere 21.5.1921, and “Caruso Voices, how they are produced", by William Lloyd FRCS “who is a well-known throat specialist who treated Caruso for many years", Daily Mail, 10.8.1921.
have to expel the offenders who were members before bringing a case before the GMC, thus placing them back in the situation of judging elite practitioners themselves.53

The CEC had considered taking the initiative, by issuing a statement of their own that signed articles on medical matters in the lay press were “incompatible with membership of the BMA”.54 This was considered “inexpedient”, and instead the committee resolved to “maintain an attitude of watchfulness...[and to] intervene on any occasion when it [seemed] wise to do so”. Press Cuttings agencies were subsequently employed to monitor such articles. This was a departure from the usual role of the CEC to await complaints from members or Divisions. At least two cases, which resulted in erasures from the Register, appear to have been ‘discovered’ in this way. The GMC was approached again by Council, citing further abuses, in 1922 and the Warning Notice was this time amended. It now stipulated that the offence of advertising “directly, or indirectly” or “acquiescing in the publication of notices commending or directing attention to the practitioner’s professional skill, knowledge, services or qualifications or depreciating those of others ... “would, if proven justify erasure from the Register.55 Now that this statement had been issued, the CEC set to work on a report, which in fact did not itself ‘ban’ indirect advertising (it did not have to), but discussed the issues involved, and effectively set a standard of good taste. Whilst members were free as citizens to take part in important discussions touching on health they were warned against commenting on frivolous or contentious matters, and against allowing “editorial extravagances” such as praising descriptions, photos and professional details.56

Eminent offenders

The committee also considered several cases brought to light by their surveillance of the Press. These very similar cases, triggered by quite similar articles had the following widely varied outcomes. A Knight57 was ‘let off’ after directly approaching the GMC, but promptly re-offended. A fashionable GP, Cecil Webb Johnson, was excused in the name of fair play by his Branch

53 Reports of Ethical Committee, Agendas, Council 14.12.1921, 15.2 and 8.3.1922.
54 CEC, 20.5.1922.
55 GMC Warning Notice June 1923, (extract).
56 CEC 14.7.1924 and 23.9.1924.
57 Bruce-Porter had trained in London, Brussels and Vienna. He had been Consultant Physician to the King Edward the VII Hospital, and President of the Hunterian Society. Medical Directory, 1925.
Council, who saw that other articles went unpunished. An ordinary medical practitioner, Hayden Brown, claiming to have a special technique for obstetric pain relief, was erased from the Register. Another West End GP was allowed to plead ignorance to his Branch Council. Thus the machinery of the Association, particularly at local level, when faced with eminent men tended to make decisions that could only engender the "feeling of injustice" which the CEC had worked hard to avoid. Harry Roberts, a prominent East End GP and medical journalist, wrote to the BMJ, apparently referring to some of the cases outlined above and a dust jacket featuring Sir Thomas Horder. He pointed out that "small men" were being punished by the GMC whilst their "big brothers" were being "tolerated without comment". He expressly challenged the whole style of ethical deliberation favoured by the BMA saying, "Sauce for the gosling should be sauce for the gander. Whatever laws we lay down should be ... defined and expressed in words ... imposed with genuine impartiality on royal physicians and the humblest medical journeymen alike."

Webb Johnson wrote to the CEC in January 1925 challenging them to discipline one of the most famous and wealthy medical practitioners of the day, Sir William Arbuthnot Lane. Lane was giving numerous interviews, and reports of his views on cancer and diseases of civilisation were appearing in several papers along with his photograph. When Anderson wrote to Lane informing him of the Association’s views on such journalism, Lane attempted to put the blame on the newspapers, and when Anderson persisted, Lane stopped replying to his letters. He did, however, take the step of publicly describing the CEC as "a self-constituted body which had no business to exist" and which sent "rude and insulting letter[s]" in a widely reported and well-received speech on health education in which he argued for the use of signed articles. Anderson wrote asking Lane to retract his comments, and for permission to publish their previous correspondence. Lane tried resigning from the Association, and when pressed again failed to answer, finally crying off further correspondence. Rather than either sue for slander and libel, or put his case before the GMC, the Association’s response was a small “Current Note” in the Journal, which simply stated that Lane

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58 Johnson was a Harley Street GP, and was a proponent of the fashionable “Twilight Sleep” method of obstetric analgesia. He had published several books on diet and one on women’s health and beauty in the early 1920’s. Medical Directory, 1924.

59 “Childbirth: Amazing New Discovery”, John Bull, 19.7.24, this article dealt with Hayden Brown and his "neuroinduction" technique for banishing the effects of fear in childbirth, CEC minutes, 23.9.1924 and, GMC Minutes, LXI: pp. 65 - 6, (25.11.1924).

60 A White Robinson, “Keeping Cancer Away”, Weekly Dispatch, 6.7.1924.


62 An account of Lane’s career can be found on pp. 351 - 2 in Appendix B.
had attacked the CEC, and refused publication of his correspondence. Even this limited action was thought unwise by Hempsons.

The New Health Society and *The Star*

Meanwhile on the 11th of December Lane launched the New Health Society at a luncheon at the Aldwych Club. Speeches were made by Lord Oxford and Asquith (the former Prime Minister), and Philip Snowden MP. The objects of the Society were “to teach the people the simple laws of health”, encourage the supply of fresh fruit and vegetables, and “to put the people back on the land”. The main method whereby information on hygiene and diet was to be put across to the people was through the medium of lectures and articles by medical men. Not only did the Society expressly ignore the ethical ruling of the GMC and BMA, but had amongst its members many doctors familiar to the CEC. Press sympathy with the aims and methods of the organisation and disapproval of the BMA and GMC were clearly expressed in an article in the *Daily News*.

“SHOULD DOCTORS TELL?”

POINTING THE ROAD TO HEALTH

BAN MUST END

CHALLENGE TO THE GENERAL MEDICAL COUNCIL

“to make the medical profession more of a lighthouse than a lifeboat”

Mr Philip Snowden MP

THE FIGHT FOR PUBLICITY”.

The BMA was described as “frankly out to protect the incomes of doctors”. The New Health Society was said to be planning to protect the medical authors of articles published under its auspices by means of an endorsement “that a number of [the author’s] colleagues do not consider that it convicts [him] of ‘infamous’ professional conduct.”

The BMA were in a difficult situation. Their ethical rules were being publicly flouted by famous and powerful doctors in the name of health education, with the full support of the press who lost no opportunity in attacking the profession and particularly the BMA and GMC as self interested and behind the times. The climate of opinion was against the BMA and GMC, particularly since these events co-incided with the furore created by Bernard Shaw and others (including, indirectly Lane himself) over the Axham case.

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64 *Daily News*, 4.1.1926.
It was in this context then that the otherwise trivial events of the lunchtime of 26th August 1926 took place. A menu featuring Lane’s thoughts on “the Athlete’s Diet” was withdrawn from Lyons’ Restaurants, and, at the request of the New Health Society, returned with Lane’s photo gummed over. The press picked this up (they may even have been tipped off) and the matter was widely and hilariously misreported as censorship by the BMA. The Star attacked the BMA particularly as opposed to health education because it would hurt doctor’s incomes, saying, “The BMA does not like the [New Health] Society for its motto is ‘Prevention rather than Cure’. To preach ‘Health without Doctors’ is the unforgivable sin to the medical monopolists”. The Star refused to apologise, and thus the Association was finally moved to sue for libel.

The Association confidently put together information demonstrating the “fact” that a “close and inseparable relationship ... exists between the interests of the medical profession and [those] of the general public”. Despite this, and the fact that their legal advisors thought they had a good case, one simple comment in their Counsel’s opinion helps to explain why the case was dropped. The Association, he said, should do everything they could to avoid exposing “the facts of the Coventry Case”, which would seriously damage their claim. Lord Dawson felt the case would “damage the BMA whatever the verdict” and volunteered to try and negotiate a settlement. The prominent doctors the BMA had planned to call as witnesses announced their inability to testify for various reasons. The BMA chose to settle out of court.

Newspapers, clinics and patients

Although the BMA had had to back down over the Star case, and had signally failed to establish a “classless” standard on health journalism, a number of cases presented to the GMC proved that patients were obtained through “health journalism”. A number of these cases have been written up by P S Brown, although with a firm emphasis on the earlier medical naturopaths, such as Allinson. Brown’s excellent article is flawed by a misunderstanding of the seriousness with which advertising was regarded. The reader of this article is left with the clear impression that these practitioners were struck off the Register for their heterodox medical views, and that the charges of advertising against them constituted a convenient ‘excuse’ for their enemies to persecute them. These practitioners were doubly transgressive - and as with all cases before the GMC, had to have incurred the displeasure of a complainant - but the fact remains that they could not and would not have had their names erased for their heterodox views alone. (As for their turning to advertising in

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65 Information for Counsel, Document A, in D106.
the first place, it could be that such practitioners had difficulty obtaining referrals and consultations from the orthodox majority, and turned to publicity to compensate for this.) Even in Brown’s account, the cases of William Lloyd and Hayden Brown’s second case before the GMC, (he was restored 3 years after the BMA had his name erased,) demonstrated that newspaper articles lead directly to the obtaining of patients through the offices of the newspapers.67

Two other practitioners investigated by the BMA were also involved “clinics” of various kinds, a topic which will be dealt with in more depth in the next chapter. As far as the Minutes of the CEC and GMC reveal, the BMA only sent one practitioner to the GMC on the charge of indirect advertising after William Lloyd and Hayden Brown.68 This was Reginald Austin, whose article in the naturopathy and physical culture magazine *Health and Efficiency* attacked the operation of appendicectomy as deadly and unnecessary.69 The BMA’s copy of this issue was heavily marked with attention drawn to editorial puffs for the “Lindlahr Nature Cure Clinic, 40 Wardrobe Chambers, Queen Victoria Street EC4” which offered to treat orthopaedic problems, mental cases, and provided psychology, dietetics and artificial sunlight. Austin was noted to be a long term contributor to H&E and thought to be involved in this clinic.70 He was expelled from the Association.

The BMA investigated another practitioner, A C Magian,71 during the 1930s Although he never appeared before the GMC, his story confirms that the idea of obtaining patients through newspaper stories was not just a product of fevered imaginations at Tavistock House. Again an unorthodox treatment was involved: the “Modified Bendien Treatment” for cancer, which consisted of a course of injections of sera prepared from fresh human placental tissue and ovarian tissue in combination with a course of iron, blood transfusion and antistreptococcal serum. It was being used by administered by Dr A C Magian initially under auspices of Royal Institute of Public Health, and later at his own St Margaret’s Clinic in Euston Road. The BMA’s first ‘tip off’ came from a doctor whose patient had seen a letter by a grateful patient of Magian’s in the *Sunday Express*. The patient was used by the BMA, through Robert Forbes and her own doctor, as a kind of undercover spy. On

67 *ibid.*, pp. 76 - 77.
68 CEC 25.1.1928, Council, 11.4.1928.
70 Note to Anderson 13.1.1928 in CMAC SA BMA D131.
71 Magian was author of *The Practitioner’s Manual of Venereal Diseases*, London, William Heinemann, 1919, and described himself as “ancien élève de l’Hôpital St Louis, Paris” and Hon surgeon Manchester French Hospital, Hon Surgeon Wood Street Clinic, for Genito-Urinary Diseases.

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enquiring at the newspaper office she had been directed to the RIPH and (with the doctor’s consent) seen by Magian and recommended a treatment costing 200 guineas.\textsuperscript{72}

\textbf{Doorplates}

Despite their emphasis on casuistry, the CEC was much stricter on doorplates and specialisation than the GMC. In 1924 they had ruled, in response to an enquiry about the use of the designation “Ophthalmic Surgeon”, that “it is undesirable that a title indicative of special practice should be used on a door-plate”, to do so “would certainly be construed as advertising”. The doctor had subsequently written to the GMC about the BMA’s ruling. The GMC had sent a copy of their reply, which pointed out that although they had never made a pronouncement on the question, they had specifically allowed doctors to use the designations “Dental Surgeon” “Orthopaedic Surgeon” and “Ophthalmic Surgeon”. Thus they would “raise no objection” to the member’s proposed plate.\textsuperscript{73} In correspondence with the GMC, the CEC pointed out that the Association had to deal with many enquiries on the subject. They always advised that “it is undesirable that practitioners who confine themselves to certain special departments of medical practice should announce on their door-plates the specialities in which they practice”. They allowed “Dental Surgeon” on the grounds that this was information the public should have access to and was equivalent to “Physician” or “Surgeon”. The underlying concern was to preserve “the proper procedure” whereby the patient should see a specialist on the advice of their ordinary attendant. They felt that plates stating speciality were not far removed from advertising as under the terms of the Warning Notice. They hoped the GMC would “see its way” to supporting the attitude of the Association.\textsuperscript{74} The GMC replied that they would “deprecate any extension” of the practice and would be very unlikely to prove a case of unprofessional conduct on the cases given, although “each case must ... be considered on its merits”.\textsuperscript{75}

In 1935, the BMA\textit{ Practitioners Handbook} still printed the advice Saundby had given 30 years before.\textsuperscript{76} Yet despite this conservatism, when asked to issue a general rule in 1923, the CEC stated that they always judged each enquiry on its merits, with regard to “local custom”, and declined to codify.\textsuperscript{77} In 1936 the Committee were not prepared to interfere in the Middlesborough area, where

\textsuperscript{72} See: Cancer clinics, the Bendien treatment, Correspondence 1933 - 1935, CMAC SA BMA D130.

\textsuperscript{73} CEC s/c, 24.10.1924.

\textsuperscript{74} letter to GMC, CEC s/c 3.11.1924

\textsuperscript{75} letter, GMC, 4.12.1924, CEC s/c 12.12.1924.


\textsuperscript{77} CEC s/c, 19.12.1923.
the “custom” was to include speciality on the plate, when a member asked them to suggest a *BMJ* article on the subject.\(^78\) This unwillingness to interfere with established practice was consistent with the Committee’s general approach, but could look anomalous in particular instances.

This was demonstrated in a case from St. Helen’s Division in 1929, which concerned both telephone directories and doorplates. The Hon. Secretary wrote setting out that although one doctor had complained that another had “Ophthalmic surgeon” on his doorplate, the accuser was described as “Ophthalmic Surgeon” in the telephone directory. Indeed Rodney Street [Liverpool’s Harley Street] practitioners were variously described in the directory as Dermatologist, Bacteriologist, Laryngologist, Anaesthetist, Gynaecological, Orthopaedic Surgeon, Psychotherapeutist, Aurist, Radiologist, and Heart Specialist. “In my view” the local Secretary wrote, “this directory advert is much worse than the doorplate and also rather takes the wind out of any straffe one could compose.” He wanted the CEC to “stir it up a bit”, but the Committee declined, resolving that since the information in the directory was only available to those who looked for it, it was not as bad as a door-plate which “obtrudes” on every passer-by. They noted that they had never pronounced on directory descriptions.\(^79\)

**Discussion**

In this chapter I have set out the medical objections to advertising and the profession’s opposing ideals of ‘success through reputation and virtue’, along with the historically less interesting and convincing argument that advertising medicine involved untestable claims and operated against the public interest. I have also attempted to draw out the fact that the history of the press and advertising themselves bear out the link that doctors made between advertising and charlatantry. Even those who embraced and relied on advertising during the late Victorian and early Edwardian period were disturbed by it, and in the early twentieth century advertising self-regulation was introduced along with medically sponsored attempts to limit the medical claims made for products in the lay press. Thus medical objections and ideals were situated within a wider set of concerns and values. There is also evidence that for many ordinary doctors the question was much more straightforwardly one of unfairness in a market that was overcrowded with competing doctors. Attempts to make medicine more genteel, and to phase out contract practice arrangements thought to be driving the overcrowded profession to penury, contributed to the pressure applied by the BMA on the GMC to translate half a century of informal condemnation (*pace* the RCP) into what was in

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\(^78\) CEC, 6.5.1936.

\(^79\) CEC, 19.11.1929.
effect a statutory ban. This bolstered, but did not displace, the appeal to “the correct professional spirit” that distinguished doctors from tradesmen and quacks.

Against this background the increasing use of eminent medical men to furnish copy for Britain’s ‘yellow press’ could only cause upset and difficulty. The issue raised profound questions about the fairness of the disciplinary structures of the profession and the social utility of its ethical rules both within and outside the profession. Yet, as archive evidence shows, the BMA’s concern that health journalism could “attract patients” to “specialists”, often offering unorthodox treatments, was not unfounded. Concern to keep the choice of consultant firmly with the attending practitioner also underlay the CEC’s advice on doorplates. The BMA could not dictate to public opinion, but it made every possible attempt to allow professional values and opinion to structure relations between doctors, patients and the public, rather than the wishes of the “influential” people involved in the Press. In the next chapter, the problems raised by different kinds of medical commerce are examined in more detail, and in this material the twin ethical issues of advertising and consultation are even more closely linked.
Chapter 10

Therapy, commerce and advertising

As we have seen, by the early twentieth century there existed a well-established body of statements, rules and ideas that made abstention from advertising a key distinction between medicine and trade. Yet ‘healthcare’ was, like all features of Victorian and Edwardian society, becoming steadily more reliant of capital outlay, and outside the State sector, more commercialised. This chapter will examine the ethics of the hinterland between classical private medical practice and commercial enterprise. This problematic territory included nursing homes, hydropathic institutions, spas, commercial treatment centres, new medical discoveries with commercial potential, and secret or proprietary treatments. In all these areas, aside from the question of patenting or profiting by medical discoveries, advertising was felt necessary and threatened the carefully cultivated relationships between patient, attending practitioner and consultant.

One historiographical problem needs to be noted however. The advertisements that are central to this chapter, despite their ubiquity at the time of publication, have not been systematically preserved. Obtaining meaningful samples of advertisements has been beyond the scope of this study - although I have tried where possible to corroborate the deliberations discussed using the other materials consulted.

Secret and proprietary medicines

Secret remedies and the Edwardian BMJ

The medical objections to secret remedies and to their endorsement or exploitation by medical practitioners have been set out in the preceding chapter. The BMA campaigned against secret remedies, but as publishers of a trade journal - a kind of publication especially reliant on advertising revenues\(^1\) - they also had to decide exactly what advertising they could and could not accept. As Peter Bartrip has demonstrated, the BMA faced an “ethical” dilemma in pursuing its campaigning to stamp out quacks and self-medication with proprietary medicines, whilst also publishing its Journal at the lowest possible cost to members.\(^2\) Ernest Hart had massively expanded the Journal by increasing advertising revenues, and in 1896 sales only covered 7% of costs. Half the late

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Victorian Journal consisted of advertisements “for almost anything that doctors and their families, friends and patients might buy ... homes for the inebriates and others in need of long term care were to the fore in the [eighteen] eighties as were bicycles [and later] motor manufacturers ... chemical and medicinal preparations loomed large.”

Between 1904 and 1908 Dawson Williams, Hart’s successor, employed Edward Harrison to produce analyses of a wide range of secret remedies, and lists of their ingredients along with their costs, were published in the BMJ. These articles were collected and published in 1909 under the title Secret Remedies. What they cost and what they contain. This book was a great success, selling 62,000 copies in 2 years. Yet the BMA was challenged by George Simmons, editor of Journal of the American Medical Association (JAMA), which was also campaigning on secret remedies and had denied advertising to four out of six secret remedies still advertised in the BMJ. Plans were made to reject advertisements for remedies of unknown composition, but “in practice the Journal continued to carry advertisements for [such] medicines”. There was also the linked problem of addictive compounds and alcohol, the National British Women’s British Temperance Association complained about advertising for “Wincarís”, which was banned from the BMJ after 1910.

The campaign continued with the publication of More secret remedies in 1912, which also dealt with postal quackery and exposés of “experts”. Yet there is little to differentiate the behaviour of the BMJ from any number of trade journals attempting to keep their readership happy with both price and advertising content. Even the Daily Mail which exposed, and entirely ruined, the remedy “Yadil” in 1924, continued advertising other such drugs. Another important point is that although Bartrip has styled the difficulties over this advertising for the Journal as an “ethical” problem, the CEC was scarcely involved in it. Where the BMA did detect “ethics” was in the conduct of individual doctors endorsing or using secret and proprietary remedies. As the JAMA put it in 1912 “Wherein is it any worse for the public to buy medicinal preparations about which it knows nothing,

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3 ibid., p.198. I have been able to locate only a very few copies of the BMJ with their advertising material in place - and most of these were special issues. No secret remedy advertising appeared in these. Copies held by BMAA.
4 Journal & Finance Committee, 10.1.1906.
6 CEC 8.6.1910, and ARM 1910
7 Bartrip gives a full account of this campaign in, Bartrip, Mirror of Medicine, 1990.
than it is for medical men to prescribe medicinal preparations about which they know nothing?" As Bartrip quite rightly points out, a meaningful study of medical ethics must look at the breaches of ethical codes as well as their content, and I shall now turn to two such ‘breaches’ of ethical standards in relation to proprietary medicines that the BMA found problematic.

"16,000 British Doctors” let Alfred Cox down, 1920

In February 1920, Alfred Cox noticed an advertisement in popular magazine, The Passing Show, for “Cicfa”. It featured a testimonial from a “Nurse Carter” under the heading

CICFA cured my INDIGESTION
Two years ago
It was a wonderful cure

The remedy, consisting of “ferments” claimed to “re-establish natural digestion throughout the whole tract”, allowing prompt digestion of the “albuminous” parts and the “starchy” part of food, and correcting “the circulation of the bile”. The advertisement went on to make the bold claim that

16,000 BRITISH DOCTORS
have taken up Cicfa. Very many of them have written to us privately of the splendid results which they have obtained by its use. When thousands of British Doctors are satisfied with Cicfa, you do not need a sample with which to test it. There can be not better proof...

Cox immediately wrote to the company, saying “I shall be glad if you will give me some evidence of the truth of this statement, which I may at once say I consider is a libel on the British medical profession”. There is not space here to rehearse the amusingly bad tempered correspondence that ensued between Cox and JE Dixon at Capsuloids (1909) Ltd. The fact that Dixon accused Cox of making “threats ... such as might have been written by the owner of some humbug patent medicine”, is sufficient to indicate its tone. Cox, finally accepted an appointment to view the evidence that supported the advertisement, and got a nasty shock. He was shown a card register

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9 JAMA, 1912, i: p. 342
10 “Cicfa” was an acronym for “Cures Indigestion, Constipation, Flatulence, Acidity” and the BMA’s analysis revealed that each pill contained, chocolate coating, the equivalent to 2/3 of a grain of pepsin BP, diastase, maltose, an oleo-resin of capsicum, cascara sagrada extract, talc and starch. More Secret Remedies, London, BMA, 1912 pp. 93 - 4.
11 Each tablet could only digest 1.5 times its own weight in starch in 30 minutes at 40 degrees according to ibid.
12 advertisement for Cicfa, The Passing Show, 14.2.1920, in CMAC SA BMA D 176
13 letter Cox, 12/2/1920, in D176
14 Cox and J E Dixon, letters, February 1920 in ibid.
giving the names of 16,000 doctors who had requested samples and 1,300 original letters from
doctors praising the product. After reading 100 of these and finding only “two or three” saying they
did not use secret remedies Cox “had seen enough”. He wrote a subdued letter to Dixon later,
giving the chemical analysis of Cicfa from More Secret Remedies.\textsuperscript{15} Dixon replied 9 months later
that their analyst must have been “an imitation; for no competent analyst, nor indeed one who was
incompetent, could possibly make such errors.”\textsuperscript{16}

Cox evidently considered this an ethical and disciplinary problem, and reported the whole sorry
story to the CEC. He stressed that when he had given evidence to the Select Committee on Patent
Medicines 1912 “I thought that there was no principle of medical practice more generally
recognised in the profession than that a doctor should not prescribe remedies, the composition of
which he did not know.” On that occasion he had argued that testimonials by medical men were the
exception to the rule, but now his confidence had “been rudely disturbed”. The question was “of
more than academic interest. ... we are inviting the medical members of the House of Commons to
assist us in getting legislation against secret remedies, and it is quite likely there will be strong
opposition put up by the patent medicine manufacturers” This experience showed that large
numbers of doctors did not support the principle on which the Association was fighting the patent
medicines industry.\textsuperscript{17} Cox was asked to draft a motion for the ARM which passed uneventfully
through CEC and Council stages which stated “that a registered medical practitioner should not
make use of, or recommend any remedy of the composition of which he is not aware”.\textsuperscript{18}

The ARM in fact changed the wording, resolving “That a registered medical practitioner should not
make use of, or recommend any remedy, the principle ingredients of which are not disclosed to the
profession”.\textsuperscript{19} It appears that the ARM felt it was unreasonable to ask individual doctors to stop
using any such drug so long as someone, somewhere in the profession had evaluated it. The
Association had assumed that individual doctors understood and complied with the “traditional”
shunning of secret remedies, and may have relied on this when continuing to advertise them in the
\textit{BMJ}. Any such assumption was wrong, as the Cicfa affair demonstrated. Cox and the CEC never
appeared to consider that the pills might actually work, even as placebos. This would have been
beside the point, they were condemned on the basis of that their composition was kept secret, and

\begin{itemize}
\item \textsuperscript{15} letter Cox to Dixon 1/3/1920 in ibid.
\item \textsuperscript{16} reply 31/1/1921 in ibid.
\item \textsuperscript{17} Memorandum, CEC s/c 9.3.1920.
\item \textsuperscript{18} Council, 14/4/1920.
\item \textsuperscript{19} ARM, 1920.
\end{itemize}
that they encouraged self-medication. The advertisements for Cicfa continued to appear and by 1924 they could claim “18,000 British Doctors” had taken up the remedy.20


In this incident a small number of named, elite doctors flouted the professions conventions of testimonials.21 In April 1929, after 3 months careful consideration and legal advice the BMJ published the following note,

YEAST AND PUFFERY

The old pharmaceutical term of yeast was Faex medicinalis. We are reminded of this rather unpleasant name for a useful substance by some highly objectionable advertisements for a proprietary brand of yeast that have been appearing lately in popular American and Canadian journals which also circulate in this country. Each of the florid advertisements ... includes what purport to be signed testimonials from medical men in Europe and the United States ... [with] a portrait of the person to whom it is attributed ... with a few fulsome words about him ... one of these advertisements bears the following legend:

FAMOUS EUROPEAN MD’S CITE YEAST BENEFITS
London, Paris, Berlin, Vienna, Copenhagen ...
What would you give for a health prescription from leaders in these great medical centres? ...
They give you, here, the benefit of their experience.

It is indeed, in the words of Hamlet, “a kind of yeasty collection”. We must deplore the fact that the owners of a proprietary article have thus made use of the names of members of the British Medical Profession. It is scarcely credible that the medical men ... have been parties to it, and we hope, therefore, that we may have an opportunity of publishing their disclaimer.22

The advertisements were for Fleischman’s Yeast and had been brought to the attention of the BMA by Sir Henry Gray, a member of the Association in Montreal.23 His original letter to the BMJ asked if the ethical rules on advertising had changed. He had been approached for a testimonial in return for “a substantial sum of money”, and had been reassured that Arbuthnot Lane, Georges Rosenthal

20 Further newspaper cuttings in D 176.
21 Aside from the condemnation in medical ethics texts, the CEC had ruled these were “undesirable” and reported those involved to their licensing corporations. See Annual Reports to ARM, 1903 - 1904, and 1904 - 5.
23 Henry Gray, KBE CB CMG, qualified MB CM in 1895 from Aberdeen, and FRCS Ed in 1902. He had acted as Consultant Surgeon to the BEF in France, and also as a Consultant Special Military Surgeon in the Home Service. Medical Directory, 1928

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and Leopold Mayer had already done so. The *Journal* passed the matter to Cox, who asked the CEC to look into it.

The CEC's response was weak, indeed Cox described them as having "cold feet" in one note. They resolved to pass the documents and correspondence to the Journal Committee with "an expression of strong opinion" that the matter should be notified in the *Journal*. The Gray/Cox correspondence was littered with phrases like "I feel no treatment can be too harsh for them", and "positively indecent". Cox privately told Gray that "I could personally have wished in spite of the legal risks the Journal should have published the whole thing with names."

Whilst the *Journal* note was being written, Gray supplied further advertisements featuring more British doctors, including Bruce Porter and Leonard Williams (who, along with Lane, been involved in the indirect advertising fiasco). After publishing "Yeast and Puffery" Horner decided to "risk" publishing, albeit with alterations, two letters on the subject. Donald Armour told of his own encounter with a Fleischman's representative, who proposed that,

> I should write a testimonial extolling the virtues of yeast ... For doing this I would receive £150. To quiet my scruples ... I was informed that four members of my profession in London had already signed the agreement ... †A consulting surgeon, an endocrinologist, a dabbler in skin diseases and a fashionable general practitioner comprised this quartet ... it is scarcely necessary to add that, whilst showing her the door, I... [told her] that there were things in life that I valued more than one hundred and fifty pounds, and that they were my self-respect and the respect of my fellow professionals.

Gray's letter also detailed the fact that "a considerable sum of money" had been offered to him by the same company, and went on;

> I am tempted to ask, 'has the ethics of the profession changed?' ... I will not insult the General Practitioner ... by suggesting that he will now be influenced by bribes from his grocer or butcher to give his name in support of local candy or sausages ... but the difference is only in degree ... unless this business is nipped in the bud (already a large one) [it will be] disastrous to the interests of the public for whom the medical profession has

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24 Sir Henry Gray, to BMJ, 10.11.1928, in CMAC SA BMA D151. This file contains 61 letters and other documents, and is perhaps the richest single file in the CMAC BMA collection, containing as it does numerous internal BMA notes.
25 Cox to Horner, note with letter, Gray to Cox, 15.3.1929.
26 CEC 8.1.1929.
27 Gray to Cox, 10.12.1928, in CMAC SA BMA D151.
28 Cox, note, 19.2.1929, in ibid.
29 *Br. med. J.*, 1929 i: p. 973., and Donald Armour, to BMJ, 14.5.1929, in D 151. The passage † - † and a facsimile of the commercial agreement signed by the four men was edited out of BMJ published version, but we can infer that the descriptions refer to Lane, Porter, Knuthsen and Williams respectively.
assumed health guardianship, and will be equally disastrous in the dishonour accruing to that profession.\textsuperscript{30}

Cox, who was "quite unofficially ... very uneasy about the inaction of our Ethical Committee\textsuperscript{31}" put the whole thing back before them in the summer. In the context of the further letters, and the continuance of the advertising campaign they decided to ask Hempson to assess the feasibility of taking Lane to the GMC.\textsuperscript{32} James Neal for one, was not certain that the evidence was sufficiently strong for such a case.\textsuperscript{33} An informal meeting was held in July to discuss the policy. Hempson had said privately he was "glad" the case was contemplated, and thought that the GMC would welcome the case, and find the evidence sufficient. Yet, he went on to bring in a number of factors which persuaded the Association to delay, and ultimately to drop their planned action. The action would have to be against all four men and since Williams was a member, they would have to instigate a BMA ethical case against him first, and expel him before they could claim, with any consistency that his conduct was "infamous". This was not all, the massive popularity of Lane, and the likely interpretation of the case as "censoring of public health education" by the BMA and GMC, all went against them. What was worse, the GMC President had actually asked the BMA to desist from acting as complainants as half the current Council were members.\textsuperscript{34}

The CEC thus asked Williams for an explanation, and received a response that, in the light of material they had in their possession, could only be interpreted as a polite lie.\textsuperscript{35} The CEC then decided to ask Marylebone Division to investigate Williams' case.\textsuperscript{36} When, after a long delay caused by the illness of an honorary official, the Division got round to approaching Williams they found that he had moved out of their area and "the gentleman d[id] not appear to be a member of the Marylebone Division".\textsuperscript{37} In May 1930 the Committee opted to take no further action whatsoever. Meanwhile the advertisements for Fleischman's Yeast continued to run.\textsuperscript{38}

Once again, élite practitioners were able to flout ideals enunciated in resolutions and ethical texts with impunity. It is scarcely likely that any of them needed the money. It is more likely that these

\textsuperscript{30} Br. med. J., 1929, i: p. 1057.
\textsuperscript{31} Cox to Gray 6.6.1929, in CMAC SA BMA D151.
\textsuperscript{32} CEC s/c, 25.6.1929.
\textsuperscript{33} Neal to Lyndon, 27.6.1929, in CMAC SA BMA D151.
\textsuperscript{34} Opinion, Hempson, dated 11.7.1929 in ibid.
\textsuperscript{35} letter, Leonard Williams to CEC, 15.7.1929, in ibid.
\textsuperscript{36} CEC, 19.11.1929.
\textsuperscript{37} Temple Gray to Anderson 28.3.1929, in CMAC SA BMA D151.
\textsuperscript{38} Gray to Anderson, 26.5.1930, in ibid.
men simply regarded the ethical rules as old fashioned and irrelevant, quite unlike those who wrote in complaining (Gray was simply the first) who were outraged at the double standards and apparent immunity of such men from punishment. One GP wrote in, with an advertisement for yeast by another company, which featured Lane, saying, "Is the GMC still in existence? If so, does it deal only with General Practitioners? I conclude the Leaders of the Profession in Harley Street are exempt or are short of work."^ ^

**Patents, profits and " traditional professional usage "**

During the early 1930s sub-committees of the CEC and Science Committees attempted to resolve the tension between the traditional view that doctors should not hold patents, and the needs of research workers and organisations to recoup some of their rising costs. It would not be appropriate to outline this deliberation in detail here, yet the ideas at the root of medical objections to patents of all kinds are pertinent to the theme of this chapter. De Styrap stated that it was "derogatory to professional character" to hold a patent on therapeutic substances, linking the issue with that of secret remedies, and thus with quackery.^ 40 Saundby made the detailed suggestion that discoveries of therapeutic foods, drugs or equipment could be patented, but the patent should then be sold outright so that the doctor was not engaging in trade.^ 41 He considered it "a grave breach of professional propriety for a medical practitioner to take any part in the manufacture or sale of a proprietary medicine, or to have his name in any way associated with it".^ 42 A review of the decisions of the CEC, undertaken when the subject came up for broad discussion in 1929, showed that no clear consensus had emerged from decisions taken on individual applications for advice.^ 43 In 1903 they had discountenanced the taking out of patents on medical inventions and discoveries, both because of the monopoly involved and the fact that an eponymous article would advertise the doctor concerned, if still in practice.^ 44 At other times the committee had allowed the use of a doctor's name on an unpatented product. They had also acquiesced to a member profiting from royalties on an invention, so long as no patent was taken out. The Committee on one occasion advised selling the patent outright for a lump sum, whilst later in the 1920s they tended to advise simply publishing the formula of a new preparation.

^ 39 Walter Smartt to BMA, not dated, in D 151.

^ 40 de Styrap, *Medical Ethics*, 1890, p. 50.


^ 42 Saundby, *Medical ethics*, 1907, p. 91.

^ 43 Memorandum, RI s/c 18/9/1929.

The trigger for this consideration was an approach from the British Dental Association, which felt it was unfair not to reward the researcher, but wished to act in concert with the BMA. The CEC formed a Research and Inventions sub-committee (RI s/c). Dr R A O’Brien of the Wellcome Physiological Laboratory was very concerned to get medical patenting abolished, and was something of a driving force on the sub-committee, along with Hawthorne and Langdon Down. The most acute problem was felt to be the increasing numbers of physiologically active isolates being used in medicine (vitamins and hormones) for which large numbers of patents were being taken out in Germany and America. The sub-committee considered the idea of “dedicated” patents, where the patent was taken out by a Board of Trustees, who could use the proceeds to fund further research, and to reward the researchers as appropriate. The Association of British Chemical Manufacturers, with whom the sub-committee co-operated, had proposed this idea. It “went a long way to removing the objections of medical men” whilst simultaneously protecting the interests of the manufacturers of the compounds.

The committee felt that there was real consensus about the undesirability of patents for medical discoveries, demonstrated by the fact that no medical man had applied for one in recent years. They also noted the adverse reaction to the MRC taking on the patent for insulin in the UK in 1923. The larger questions of policy were not included in their first resolution that

it is ethically undesirable for a registered medical practitioner who makes an invention or discovery in the medical field, to derive financial benefit from the sale of the rights of such invention or discovery, or from royalties for the use of them.

Their report, detailing the option of “dedicated patents”, was not approved by the ARM, which disliked the idea of any patents at all. It also triggered specific complaints from some research workers that they were as worthy of reward as the physician or surgeon was of his fee. Others complained that the purpose of the patent, to make information available rather than to conceal it, had been overlooked. A fresh sub-committee of the Science Committee was unable to resolve the

45 The sub-committee was composed of the Chair CEC (Lyndon), chair RB (C O Hawthorne), W E Dixon, R Langdon-Down, James Neal, R A O’Brien, and H S Souttar.
46 RI s/c 18/9/1929, 1/10/1929.
47 RI s/c, 4/11/1929.
48 letter, Dr Renshaw, RI s/c 2.6.1930
problem, a situation that clearly irritated the ABCM. The BMA was still working on a model that outlined the behaviour of an individual medical man, rather than attempting to solve the complex collaborative problems faced in research and industry. A resolution proposed for the ARM of 1931 stated that,

The Association approves the traditional professional usage in accordance with which it is unethical for any medical practitioner who discovers or invents any substance, process, apparatus, or principle likely to be of value in the treatment of patients to act against the public interest by unduly restricting the use and knowledge of such discovery or invention for his own personal advantage.

A conference attended by representatives of the MRC, the RCP and RCS (in a rare moment of cooperation), the Chairmen of the Science and Ethics Committees, and (apparently through sheer respect for their seniority and experience) Langdon-Down and Hawthorne, met and reached a consensus in 1932. They recognised the need to protect industry and proposed that synthetic compounds be “dedicated to the use of the public” in Britain, and effectively patented in international law. In the meantime, they recommended that “the special position held by medical men in the community renders it undesirable that they should apply for patents in the medical field”.

Advertising Commercial Therapeutic Institutions

Nursing Homes, fashionable therapy and the ‘many headed Hydros’

These paragraphs are intended to serve simply as a short introduction to this section and will only attempt to sketch out the main features of a vast “twilight zone” of medical facilities and provision that existed between hospital, panel and private GP work. Abel Smith has shown that nursing homes were an innovation of the 1880s and 1890s and helped provide some in-patient facilities for the better off in substitution for the hospital accommodation offered for the poor. He also demonstrates that the involvement of doctors in these homes, at a time when hospitals were excluding ordinary practitioners, encouraged the BMA to defend them. These institutions allowed attending practitioners to retain more control of their patients, and, it seems provided an important

50 It's members were, Prof. A Clark, W E Dixon, F Temple Grey (who had moved with Graham Little to send it back at ARM) and Humphrey Rolleston, C O Hawthorne, Langdon-Down, Ewen Maclean and James Neal. later they also co-opted Henry Dale and Prof. A J Clark
51 CEC, 15/12/1931.
52 ARM, 1931, Min. 33.
53 Conference 20/4/1932, CMAC SA BMA D244.
54 ARM, 1932.

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source of income for many. Numbers of beds increased dramatically. In 1891 there were 9,500 nursing home and convalescent beds in England and Wales, in 1911, 13,000 and in 1921, 40,000 of which 26,000 were in nursing homes.\(^5\) When moves were made to regulate nursing homes by law in the 1920s, the BMA resisted legislation, worried about its impact on the “hundreds” of doctors who treated patients in their own homes, and the possibility that lay committees would be allowed to inspect records. Only this last point was conceded for the 1927 Nursing Homes Act.\(^7\) Thus at one end of the market there were beds for patients in doctors’ own houses, and cheap boarding houses for the vulnerable, and at the other huge private hospitals like the London Clinic, founded in July 1929. The heterogeneity was further increased by the fact that some homes “specialised”, in surgical cases, in massage or rest cures, or in dietetics,\(^8\) “twilight sleep” analgesia for childbirth, and in some cases in abortion.\(^9\) Another class of homes, frequently advertised in the BMJ were those offering treatment for inebriety and alcoholism, and numerous businesses catered for the feeble-minded and psychiatrically afflicted members of better off families, including Reginald Langdon Down’s home, Normansfield.

Another important group of concerns were hydropathic institutions (hydros) which had sprung up throughout Europe to carry out water cures developed by an Austrian peasant, Vincent Preissnitz and his medical and lay followers. Centres like Malvern were genteel, and medically controlled, whereas John Smedley’s Hydro in Matlock combined Methodism, self-help and radical cold water cures for the middle and lower classes.\(^6\) Rees states that in 1891 Britain had 61 hydros “of substantial size and reputation, catering largely to a middle class and marginally aristocratic clientele. In addition there were many smaller hydros patronised by the working class.”\(^6\) It is clear that by the 1900s innumerable small concerns were characterised as hydros, and as the various physiotherapeutic fashions of the early twentieth century came and went, an increasing number of therapies were offered by institutions ranging widely in size and character. Whilst some evidently undertook serious and complex treatment, many were also essentially resort hotels with physiotherapy thrown in, or the equivalents of today’s health farms.

\(^5\) ibid., p. 189.
\(^6\) ibid., p. 341.
\(^8\) ibid., p. 191.
\(^6\) ibid., p. 28.
These therapeutic innovations have been neatly summarised by Barclay, as they affected the Chartered Society of Physiotherapists,

In the [1890s], gentle massage was regarded as a panacea in neurasthenia and efficacious in fractures; for some time it coexisted with Swedish Gymnastics but during the 1WW both were overtaken by electrotherapy, hydrotherapy and exercise machines; in the 1920s machines fell from grace and ultraviolet light was all the rage; in the 1930s it was keep-fit for all and hydrotherapy for rheumatism. 62

This tendency for fashion in therapeutics was a problem for physiotherapists and their reputation, but must also have affected the homes and hydros that offered them, as Farquar Buzzard commented in 1931,

a new 'stunt' ... appears on the field. It is eagerly grasped both by the qualified and the unqualified practitioner, exploited for all it is worth, and perhaps for a great deal more; it is dropped when the public has tired of it, and finally replaced by another. ... No wonder the orthodox purveyor of cures is confused with the layman; we with the quack and the charlatan. 63

One advertisement from a Nursing Homes directory of 1938 bears these points out well. 64 It announced,

The Heywood Private Nursing Home
30 Porchester Square, Hyde Park, W2
 Patients received under the care of their own medical men.
§Up-to-date theatre. §Milk direct from the farm daily. §Beautiful Garden for convalescents
FULLY EQUIPPED ULTRA-VIOLET RAY CLINIC
Treatment given in patient's own home if required
Plombière treatment
given by specially trained nurses
Massage and Electrical Treatment
under medical direction
Specially equipped annexe for maternity cases at much reduced fees

The introduction to this Directory stated that "a high proportion of homes disappears each year from the list to be replaced by new comers".

63 Farquar Buzzard, Founder's Lecture JCSMMG, March 1931, p. 240
64 Nursing Homes 1938 A directory of nursing and convalescent homes in England and Wales, etc, South Lancing, J. E. Hosking, 1938, p. 180.
Some of these therapies, particularly medical electricity and Zander exercise machine therapy were carried out beyond this kind of residential setting in out-patient departments, and sometimes in commercial concerns. Ueyama has described the growth in such treatment centres in the late Victorian period, as well as the role of medical men in supplying testimonials for commercial brands of foods and drugs. The response of the RCP, was a resolution of 1888, “that it is undesirable that any Fellow or Member of the College should be officially connected with any company having for its object the treatment of disease for profit.” As we shall see, the BMA made an important distinction between residential settings in which doctors tended to have more clinical and financial involvement and these more frankly commercial undertakings, although it was only the threatened establishment of a “chain” of such treatment centres that galvanised them to action.

Advertising commercial therapeutic institutions up to 1920

The first involvement of the CEC with the advertising of these commercial therapeutic institutions was in the question of hydros. The committee received a “great many” complaints about the advertising of hydros in the first years of its existence. It was felt to be particularly unfair if family practitioners with part-time ‘appointments’ to such institutions were mentioned in such advertising, but there were also objections to the restriction of attendance to patients at a Hydro to those with appointments to its “staff”. In other words many doctors wanted these institutions to be open to all local practitioners with “free choice” of doctor. The CEC decided to questionnaire the Divisions on the issue in 1905. 58 out of 112 Divisions that answered were absolutely against any advertising, and indeed 25 objected to any such institutions existing at all. 16 answered that it was only a problem for part-time doctors who could, through the hydro’s advertising, gain patients for the rest of their practice. The ARM passed a motion banning these institutions from advertising in the lay press:

That members of the profession who act as medical officers of hydropathic and similar establishments should make it a condition of their engagement that their names shall not be inserted in any advertisements of such institutions except in advertisements in medical journals.

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66 RCP(L), The Charter, Bye-laws and Regulations of the Royal College of Physicians of London, 1933, (Resolution of 25.10.1888.)
67 Appendix C, ARM, 1905, BMA A A/1/1/3.
68 ARM, 1905, Min 130.
This very clear resolution however only referred to hydropathic institutes by name and the committee’s decisions on other similar institutions established no clear pattern. In 1910 the Committee made no objection to a medical practitioner acting as director of a nursing home, and as medical officer, or to his name appearing in the prospectus, but warned that “on no account should a list of his past offices appear on the prospectus.” Later decisions reflect a further loosening in stance. A “simple announcement” of a home in the lay press was thought unobjectionable in 1913. Financial involvement in nursing homes had been frowned on in 1905, but in 1914 the Committee had no objection to a doctor’s financial interest in nursing homes so long as this was declared to patient.

The long campaign for clear rules, 1920 - 1927

Before considering the frankly tedious course of the BMA’s deliberations on this question, it is worth setting out a basic map of the issues involved. The business of this deliberation was tortuous partly because the situation was extremely complex and changing all the time, and partly because the Council and the ARM appear to have been more impressed by the vested interests of their members, and force of custom, than the arguments and principles put forward by the CEC. It seems to have been a tacit assumption that if the medical department could deal with enquiries, this would be better than presenting every enquiry with an ethical aspect to the CEC. Nursing homes and other institutions could be divided into those that did not involve medical treatment or medical men at all, and those that had medical staffs and offered medical care. Some of either type were owned partly or wholly by doctors. Homes and other institutions could be advertised either in the lay or the medical press, or both, and could mention specifics of therapy in more or less sober terms, and might or might not mention the identities of their medical staff or proprietors. The BMA could control practitioners by issuing advice, or by censure if complaint arose, or by issuing general resolutions through the Council and ARM. However, it could also sanction or decline advertising copy for the BMJ, and since the Journal had a huge medical circulation, refusal of advertising in it would be a serious blow to a home seeking medical recommendations or patronage. The BMA eventually settled on a policy that forced commercial therapeutic institutions to advertise modestly in the medical press alone. But a great deal had to change before the Council and the ARM could be induced to endorse this policy.

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69 CEC, 8.6.1910.
70 CEC, 3.1.1913.
72 CEC s/c, 24.4.1914.
In late 1920 the sub-committee considered a memorandum by Anderson on the subject of advertising “Nursing Homes and Kindred Institutions”. His concern was the lack of clarity on the ethics of placing advertisements for these institutions in the lay and medical press, and the fact that past decisions of the committee were not a helpful guide when dealing with enquiries to the Medical Department. The same meeting considered a number of complaints over “palpable untruths” in advertisements for a nursing home offering scopolamine/morphine analgesia (“Twilight Sleep”) for maternity cases. With this in mind, they drafted the first of a long succession of resolutions intended to form BMA policy. This stated that it was “undesirable” that advertisements for “nursing homes and kindred institutions with which medical practitioners are professionally associated” should appear “in newspapers or periodicals, not primarily intended for circulation to the medical profession”.

Council rejected this recommendation. In early 1921 the problem was considered again along with a memorandum by E R Fothergill, a Council member who ran a nursing home in Brighton. Their resolution, he said, “suggests no nursing home should advertise. If you mean that, why not say it? Only; not a single person would agree with you”. Even if the rule were made to cover homes “in which medical practitioners are financially interested”, 50 to 75% of the “Homes Doctors” were financially involved, and “you are asking for trouble ... your dictum would be ignored and laughed at”. Worse still the resolution was, he said, based on “false premises”.

You are trying to place a nursing home on the same ethical plane as a registered medical practitioner. This is quite wrong. A doctor who advertises suggests that he has some special medical or surgical acumen which his rivals colleagues have not. A nursing home does not so pretend; for the simple reason that it does not provide these commodities per se. What a nursing home provides is situation (quiet, sunny, healthy), nursing, beds, furniture, operation theatre, baths, X-ray etc. etc. ... A nursing home allows, except in a few instances, the doctor to follow in his own patient and the patient to have in any consultation wished.

The CEC drafted fresh recommendations that stated first, that that ownership and treatment needed to be separated, second, that a doctor should not hold an appointment at a “sanatorium, hydrotherapeutic institution, private asylum, nursing home or kindred institution which is run for private profit and

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73 Memorandum, CEC s/c, 9.11.1920.
75 Council, 16.2.1921.
76 See biography, p. 325.
77 memorandum, CEC s/c 11.3.1921.
which advertises elsewhere than in publications primarily intended for circulation to the medical profession."  

Again, Council rejected these resolutions.  

The CEC decided not to take any further action on the question, but tended in practice to stick to the policy Council had rejected when asked about specific cases. For instance in 1923, on at least two separate occasions, they advised doctors against advertising homes they owned in the lay press.  They also tended to maintain a strict line on doctors’ names appearing in promotional literature for these homes. For instance a lady practitioner, giving Twilight Sleep analgesia at a home in Wolverhampton which advertised in the lay press, was told that the Committee “strongly objected” to her name appearing in a pamphlet for the laity on the home’s services. She was also advised that she should “refuse to be associated with [the home]” if they did not comply with this.  

The Medical Department were not happy however, since they were still unclear what advice to give enquiring members. They could not assume that the Council had rejected the draft resolutions because they approved the advertising of nursing homes, and “the frequent number of enquiries on this subject afford clear intimation that ... authoritative pronouncement” was required. A set of resolutions proposed by Hawthorne was put forward, but the Committee’s Report to Council mentioned the “lack of unanimity” on the question. They stated that a “custom ... had grown up [of] advertising of nursing homes, not only in the medical journals, but also in the lay press”. “Several members of the Committee” felt this “custom had been acquiesced in for so long” particularly in the case of “certain well-known institutions”, that the Council would be taking “a most unfortunate step” in expressing the opinion prepared by the Committee. The problem was that “the committee ... recognised that custom, even where such custom apparently conflicts with the high standards of medical ethics, has a bearing on the pronouncements which the Committee is called upon to make”.  

In fact they had put forward resolutions that recognised this “custom”. Thus the resolutions were that institutions not offering medical advice or treatment could advertise anywhere, and that  

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78 CEC, 1.4.1921.  
79 Council, 20.4.1921.  
80 CEC, 25.10.1921.  
81 CEC s/c, 25.6.1923, CEC s/c 23.10.1923.  
82 CEC s/c, 23.10.1923.  
83 memorandum, CEC s/c 23.11.1923.  
84 CEC s/c 20.2.1924  
85 Agenda, Council, 11.6.1924.
advertisements in the medical press for institutions involving doctors could include their names. A further statement was put forward for endorsement that noted that whilst some institutions offering medical care did advertise in the lay press, and the Council recognised "the force of custom in this respect, [i]t would prefer to see such advertisements withdrawn, and trusts that the practice will not be extended". A further resolution stated that "it is not consonant with professional integrity" to withhold from a patient, who had been recommended a home, the facts of any financial interest of the doctor.86

The Council disagreed over this "duty to inform" which was the only contentious part of the proposals, and they were rejected by the ARM of 1924. All that had been achieved by the summer of 1924 was that the Association had endorsed both the advertising of purely lay homes which provided no medical advice or treatment, and the advertising of medical homes and their staffing details in the medical press. Neither of these practices had ever been in doubt and there were still no prohibitive resolutions dealing with the kinds of institutions that were actually causing problems.87 The CEC, however, saw "no reason to modify their opinion ... that if a medical practitioner has a financial interest in any Institution to which he refers a patient, it is not consonant with professional integrity that a knowledge of such interest be withheld from the patient."88 Council watered this statement down, resolving "that if a medical practitioner has a financial interest, involving his possible pecuniary gain, in any institution to which he refers a patient, it is desirable that he should disclose this fact to his patient". Furthermore they never referred this on to the ARM, preventing it from becoming "official policy", whilst at the same time allowing the Medical Department more to go on when advising members.89

By early 1926 however, the CEC was seeing multiple abuses of the advertising of nursing homes in the medical and lay press. They took, for instance, "grave exception" to the private practice address of a doctor (1 Harley Street) appearing in connection with an advertisement, and another that "eulogise[d] the special methods of treatment" used at a home for alcoholism drug habit and neurasthenia in Torquay.90 The advertisement was referred to the Journal Committee, who were able to cite another 8 examples of the same practice.91 The problem was compounded by the observation that the BMJ was available in London clubs - (in fact it was also available on

86 ibid.
87 Minutes ARM 1924, 150 and 151
88 Council agenda 17.12.1924.
89 Council, 18.2.1925.
90 CEC s/c 9/2/1926.
91 CEC, 9/3/1926.
newsstands) thus blurring the distinction between lay and medical press. The sub-committee recommended no advertisement should be placed in the medical press containing laudatory statements or the consulting addresses of members of staff. Once again some Council members were unhappy, but attempts to suppress the motion failed, and thus the ARM of 1926 considered the resolution that

it undesirable that there should be inserted in the medical press or in other publications primarily intended for the medical profession any advertisement of a therapeutic institution which includes any laudatory statement of the form of treatment given, or the private address or consulting hours of a member of the medical staff; but that there is no objection to the name and qualifications of medical officers of the institution being given.

The ARM endorsed the resolution with only a slight change in the wording, that did not affect its meaning. This was no real advance however, since many contentious practices were not included in this statement. The British Journal of Actino-therapy [ultraviolet or sunlight treatments] wrote to the BMA complaining that whilst they refused to carry advertisements for centres where lay therapists administered actino-therapy, the BMJ still carried them. The Committee once again drafted resolutions for the Council and ARM. These specified that for medical press advertising to be allowed, an institution had to offer equipment or methods “reasonably regarded as outside ... general practice”. A further condition was that no patients should be treated there except those referred by a registered medical practitioner, who should be responsible for their care. Lay press advertising would disqualify the institution from advertising in the medical press. Council simply sent the resolutions back to the CEC who, apparently weary of trying to persuade the Council on a matter of principle decided not to press the matter, but simply to await suitable cases to make the point for them.

“Let Sun Ray Cure Your Deafness”: or the tonic effect of a real threat, 1928

This tactic was prescient. Within a year they had a problem to present which even the Council could not ignore. The “threat” of the National Sun Ray and Health Centres, Ltd (NSRHC) was enough to induce the Association to pass resolutions very closely based on the drafts they had just rejected. The nature of the company and its negotiations with the BMA are a useful introduction to

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92 CEC s/c, 15/6/1926.
93 Council 13/10/26
94 ARM, 1927, Min 41.
95 CEC s/c, 1/2/1927.
96 Council 8/6/1927
97 CEC, 10/1/1928.

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the later history of the Association’s attempts to regulate clinics in the 1930s. In a long memorandum for a special meeting of the CEC, Anderson set out the main details. The NSRHC had been set up in July 1927 under the chairmanship of Sir Robert Lynn MP. It had a remarkably broad remit, “to carry on the business of proprietors of Electrical and Sun Ray Treatment Establishments, or of any institute, establishment or premises [for the treatment of virtually any disease by any means], and to run nursing homes, baths, gymasia, to deal in drugs, and medical appliances, and all needs of hospital patients and to provide refreshments for patients using the premises”. The company was to take over some clinics previously owned by a Mr Arthur Lewis. Dr Percy Hall was general medical advisor, provisionally, and was trying to get the company run along lines that the BMA would approve.

Following a meeting with representatives of the Company in August 1928, Anderson wrote to Sir Robert Lynn setting out the concerns of the Association. The nub was the question of whether or not the company, which would naturally want to advertise, was to take patients who had not been recommended or referred by their own doctor. He wanted the company to submit draft advertisements to the CEC. Anderson also stressed the need for active rather than nominal medical oversight of treatment, and guarantees of the skill of the “auxiliaries”. What was more he would “emphatically” advise any doctor against working for Mr. Lewis.98 Lynn’s reply was non-committal, and didn’t reassure Anderson. The company would appeal for patients “primarily” from the medical profession, and would let the patient’s doctor know if their patient attended. They would allow attending doctors to come to the clinics and agree treatment, but otherwise all treatments were to be prescribed by a resident medical officer. Whilst the NSRHC wished to “avail itself of the precedents already created” which allowed advertising by nursing homes and hydropathic institutions, they would “as far as possible” advertise only in the medical press. The British Medical Bureau [a medical employment agency] had been asked to hold back advertisements for Resident Consulting Physicians till all was settled, and Lewis was to be removed.99

Anderson brought an advertisement for one of the clinics that invited the public to “Let sun ray cure your deafness” to the attention of Percy Hall. Hall replied he was “painfully aware” and “disgusted” by the activities of Lewis who he claimed, had been “dealt with” but complained that they could not replace staff because “you yourself - no doubt quite discreetly - have closed this avenue [the British Medical Bureau] to us ... We are doing all in our power, and can only reiterate

99 Lynn to Anderson, 4/9/1928, in ibid.
that the Augean stable we have found cannot be cleansed in a day, or even a month.100 (In fact the BMA had a controlling share in the BMB.101)

Anderson argued that “important questions of principle are raised by the formation of this Company ... and a definite policy must be laid down.” The case was not a simply isolated example.

In recent years institutions and clinics which provide physical and electrical treatment have been established in increasing numbers; many of these are controlled and managed by unqualified and untrained persons. This form of treatment now has a definite place in medical practice, and it therefore seems to be desirable that steps should be taken to see that institutions and clinics at which it is practised are conducted on lines which are in harmony with professional custom. If no such steps are taken it appears to the committee that this class of work will get more and more into the hands of laymen who will exploit it from a purely commercial point of view, without reference to the wishes or traditions of the profession. ... if this organisation can see its way to conduct its business on line laid down by the Association a valuable precedent will have been established.

However “the question of advertising [wa]s an acute difficulty” since the Council resolution of 1924 had acquiesced to the custom of advertising.102

The CEC drafted a vague set of resolutions that may have been designed to meet the Council’s apparent objection to a principled approach on the subject. Since quite different resolutions were eventually passed, the discussion of Council is of more interest here. One Councillor, Dr Hudson, stated that he felt that such institutions were in direct competition with private practitioners, whereas the old type of nursing home or hydro had not been, and would have an unfair advantage. Lyndon wanted a watertight and universally applicable “future policy”, that did not make any distinction between types of institution. Hawthorne, referring to a “glaring circular” containing testimonials for the NSRHC, thought that the BMA should have nothing to do with such outfits, and was concerned that they could find themselves in opposition to the GMC. Peter Macdonald felt the “facts have to be faced. There is going to be an expansion of the public supply of these forms of treatment upon an economic basis which people generally could afford.” Robert Bolam on the other hand, pointed out that far from filling a need, the treatments on offer were not in fact difficult to obtain in the areas in which the clinics were proposed. The company could only succeed by taking business away from private doctors and any doctors associating with them would risk

100 correspondence quoted in memorandum, CEC 18/9/1928.
101 ARM 1925 mins 57 - 9 had resolved to form a locums and assistants bureau. In 1927 the Association had bought half of the issued shares of the Scholastic, Clerical and Medical Association Ltd, and thus had one-half of the representation on the Board. ARM 1927, Mins 19, 20. The agency was renamed the British Medical Bureau.
102 memorandum, CEC 18/9/1928.
removal from the Register for advertising. E B Turner pointed out that the Representative Body had asked Council to do everything it could to prevent encroachments of private practice, “and if there was one encroachment which was bad, it was this.”

So once again the CEC considered the whole matter at a meeting for which Hawthorne submitted a huge memorandum. His main proposal was to reverse the suggestions made by Fothergill in 1921, and to place these institutions in the same ethical frame as a consultant medical practitioner. The CEC, said Hawthorne, was faced with lay-financed schemes offering “physical, mechanical, hydropathic, electrical or radiation methods” of treatment, whose organisers “profess a desire to conduct their organisations on a line approved of by the medical profession”, and the Association had to decide how to respond. These schemes had in their favour the fact the equipment was expensive, and that using lay people to administer the treatment cut costs. Furthermore, working with large numbers of patients would increase knowledge and expertise. Such institutions would “probably increase in number” and he cited the “Rheumatism Clinic now being organised by the Red Cross” which had been supported by prominent doctors. Since the number of practitioners in a position to offer this treatment was “not large”, and assuming the treatment had value, then it must be “in the public interest” for it to be available to “all classes”. For all these reasons the Committee did not feel comfortable with “unqualified opposition”.

However, these organisations could be “prejudicial to the public welfare”. They were basically commercial in nature, seeking high profits and quick returns, and their advertising would undermine professional confidence and therapeutic worth, leading eventually to their failure. Medical supervision was needed “in the interests of patients” to ensure “accurate observation”, and professional evaluation. Proper referral patterns would “help to command the goodwill for the profession generally”, guarantee that an “independent witness” thought the treatment suitable, and provide “impartial evidence” of efficacy. Given all this, and valid, effective treatments, these businesses would “manifestly” not need lay press advertising for patients. Hawthorne’s view can be summed up as an argument for making these institutes as like individual doctors as possible, subject to the same general ethical framework and included in the “friendly and scientific” world of


104 He was referring to the Pete Clinic, see Cantor, David, “The contradictions of specialization: rheumatism and the decline of the spa in inter-war Britain”, in, Roy Porter, (ed), *The Medical History of Waters and Spas, Medical History Supplement no. 10*, London, Wellcome Institute for the History of Medicine, 1990, p. 143.
legitimate medicine allowing "cultivation of confidential professional relations between the medical staff of the institute and the patient's own medical advisor".105

The NSRHC had in the meantime accepted Anderson's suggestions or blandishments as to advertising in the lay press, and had resolved not to do so. The CEC however, was not letting its guard slip, and resolved that advertisements for the centres should only be accepted by the BMJ if they actually contained statements that the centres were not advertised in the lay press, and that they proposed to "conduct their centres in accordance with the recognised ethical principles of the profession" subject to the satisfaction of the Medical Department.106

A policy at last

The subcommittee formulated yet another set of resolutions for Council and ARM which recognised a difference between nursing homes, sanatoria and hydros and commercial treatment centres, on the basis that "so-called physio-therapeutic and Electrical Treatment Institutes ... are essentially for the treatment of non-resident patients who go there for treatment only, not for rest or amusement".107 At the ARM, after a brief struggle in which Fothergill tried unsuccessfully to get the ban on lay advertising overturned, it was finally resolved that,

the Representative Body reaffirms the opinion it expressed in 1924 that the profession generally have acquiesced in the custom, now of long standing, of advertising in the lay press, nursing homes, sanatoria, and hydropathic institutions, and feels that in any policy formulated by the Association, regard must be had to this custom; and further that the Representative Body takes no exception to the association of registered medical practitioner with an institution for the treatment of patients by physio-therapeutic and electrical methods, provided that the following essential conditions are strictly adhered to:-
a) That the institution is not in any way advertised to the lay public
b) That the treatment of all patients is under the direct control of a registered medical practitioner who accepts full responsibility for their treatment
c) that the relation between the medical officer of the institution and private practitioners conforms to the usual ethical procedure between consultant and private practitioner. 108

The BMA now had something like a coherent publicly stated policy on these commercial therapeutic institutions, which was to guide their action on similar schemes for the next 10 years.

The policy was, however based on a very vaguely drawn distinction between "nursing homes, sanatoria and hydros and pathic institutions" and "institutions for the treatment of patients by physio-

106 CEC, 13/11/1928.
107 CEC s/c, 18/12/1928.
108 ARM Minute 144, 1929.
therapeutic and electrical methods”, leaving the CEC really to decided whether or not a particular set-up was to their liking. So what was the basis of the distinction and the concern?

The Council’s argument, adopted by the CEC, was that these newer institutions were different in that they did not allow the attending practitioner to follow their patient, and that they provided therapy for out-patient, rather than in-patient treatment. Other differences existed however. The first of these, to some extent alluded to in the discussion, was that they were providing services to a group of people who could not afford them from the private doctor, or plush hydro. They were thus underselling services already provided by doctors or by businesses with which doctors were used to co-operating. And this was to be high street trade rather than business conducted for the well to do in genteel surroundings: the NSRHC was going to operate all over the country, like Woolworth’s. Rather than locally based individual businesses, with which local doctors were familiar, these clinics were going to be visited on local medical communities by a large company, with no relationship to them. As with so many things, the objection to the clinics was not so much what they were doing, but the threat that they would exist completely outside the carefully constructed world of intra-professional relations fostered by the BMA.

**Clinics and Spas in the 1930s**

In the 1930s serious attempts were made to boost the fortunes of British spas. A Ministry of Health report of 1928 highlighted the huge amounts of morbidity caused by rheumatic complaints among the working classes, but spa treatment was never recognised as an additional benefit under National Health Insurance. The spas also attempted to promote themselves to the better off, in competition with continental resorts like Pistany. Indeed attempts were made to import the methods used by these centres. As Cantor has shown, spa town authorities wanted to get ‘bums on seats’ and doctors wanted to promote their work with spa resources, sometimes within the rubric of rheumatology, sometimes in opposition to rheumatologists who were not spa doctors. There was a problematic indeterminacy as to whether these spa doctors were specialists in a place, a set of techniques, or in a set of diseases. Thus despite the emergence of organisations like the British Health Resorts Association (1931) and the International Society of Medical Hydrology (1921), spa treatment never really took off in twentieth century Britain. It blended into the rag-bag of hotels, hydros, nursing homes and other concerns offering selections from the shifting smorgasbord of physical therapies.

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During the 1930s a large number of "clinics" of various types attracted sufficient interest from the CEC to generate their own files of material, but there is certainly not space here to rehearse more than a small sample of this deliberation.

The Buxton Clinic: 1934 - 1938

The Buxton Clinic was hybrid of a number of types of institution, and prompted consideration of a number of ethical issues. It aimed to meet several of the problems of providing spa treatment for the less well-off by combining a number of different elements of more conventional therapeutic institutions. Dr C W Buckley, a "senior" doctor at the Devonshire Hospital, Buxton, wrote to Anderson to clarify some of the arrangements and check that the publicity material for the Buxton would not meet with disapproval. He outlined the scheme in some detail.111 The Clinic was "primarily for the benefit of those above the hospital class who are unable to afford adequate treatment otherwise" and although privately financed, was to limit its dividend, and thus "has a philanthropic basis." The patients paid a lump sum per week and the doctors were paid by the Clinic according to number of patients seen.

The catch was that only those doctors approved by the directors were to be eligible to treat patients in the Clinic. This was decided in order to avoid the situation affecting the Devonshire Hospital where all local doctors had beds and offered widely varying standards of service. For patients who did not select an approved doctor, the Clinic directors were appointing a staff of four, all senior staff at the Devonshire Hospital, who were to take such patients on a strict rota basis in return for fees "on such a scale as the philanthropic idea justifies." This plan was objected to by local men on the grounds that all should share in the "'kudos' of being on the staff ... irrespective of their having experience or not."112

Buckley wanted guidance on the brochure, which would go out to medical men and interested lay people, and which would contain the names of the staff. Anderson, in reply, pointed out that since the brochure would have lay circulation it should not bear the doctors’ names; furthermore the clinic directors should only notify the profession, as opposed to the public of the existence of the clinic. He was concerned about a precedent being set by a clinic conducting "an advertising campaign" and receiving "patients cheaply and without enquiry into economic circumstances" causing patients to be "deflected there who otherwise might have sought advice and treatment elsewhere." He wanted the CEC to consider the matter, and was at pains to stress that its "purpose

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112 Ibid.
... [was] not merely to be critical and censorious, even condemnatory: rather it would wish to be helpful to all enterprises calculated to promote the public interest."\textsuperscript{113}

The sub-committee, at a meeting attended by Buckley, resolved that the Clinic “could not be properly advertised in the lay press, and further, might be utilised by unsuitable patients unless an income limit governing admission was enforced”.\textsuperscript{114} Shortly afterward the Deputy Medical Secretary (presumably Forbes) visited Buxton and negotiated a “sound working basis” for the Clinic. Patients were only to be admitted on the recommendation of their attending practitioner, who was to indicate that they could not afford full private fees. The Clinic was to appoint an “Advisory Medical Board” whose names were to be made available only to doctors, along with a “list of all local practitioners ... who have indicated their willingness” to oversee patients at the clinic. If the attending practitioner had not nominated one of this latter group, a member of Advisory Board was to accept responsibility. Even with all these safeguards in place, the CEC still thought “it undesirable that the facilities afforded by the clinic should be advertised in the Lay press”.\textsuperscript{115}

Dr L S Potter, the Hon. Secretary of the Buxton Division, wrote in late 1936 to say that the results of medical press advertising were disappointing, and that the Division had passed a resolution in which they offered the Clinic a \textit{quid pro quo}. “Free choice of doctor” had been in place in theory, but patients were almost always seen by the “member of the Advisory Medical Board who attend[ed] on that day.” They resolved that,

\begin{quote}
this meeting sees no objection to the insertion in the personal columns of the lay press of a paragraph drawing attention to the facilities offered by the Buxton Clinic; provided that the principle of free choice of doctor from among those who have expressed willingness to serve, and by those patients who have not already made a selection is maintained and \textbf{applied in practice}.\textsuperscript{116}
\end{quote}

The Secretary of the Clinic also wrote stating that the “restricted system of advertisement is inadequate if the Clinic is to be self-supporting, and ... the success that was anticipated”.\textsuperscript{117}

Despite their emphasis on local agreement and custom in other areas, the Committee interpreted the ARM resolution of 1924 on hydropathic institutions to indicate that “there should be no

\begin{footnotes}
\item[113] Anderson, reply, 12.12.1934, in ibid.
\item[114] CEC s/c, 15.1.1935.
\item[115] CEC, 19.2.1935,
\item[116] letter, L S Potter, 20.11.1936. Potter later became a member of CEC.
\item[117] letter, Secretary, Buxton Clinic, 14.12.1936 in CMAC SA BMA D 114.
\end{footnotes}
advertisement in the lay press ... of the Buxton Clinic,"\(^{118}\) a decision ratified by the Council.\(^{119}\) The problem was eventually resolved in 1938 when the clinic, in a move that exposed the inconsistency of the Association’s resolutions, reclassified the Clinic as a nursing home, whose advertising to the laity would stipulate that admission was only on recommendation of patient’s “own doctors”.\(^{120}\) The new brochure carried a foreword by Lord Horder, who declared himself

a strong advocate for many years of the principle and practice of the “Clinic” where teamwork may be carried out in the best interest of the patient, I welcome the advent of such an institution at Buxton ... teamwork demands a good equipment, both on the laboratory side and on the physiotherapeutic side, and these cannot be provided in the patient’s home. ... To give the same facilities to the “patient of moderate means” as are afforded to those who are eligible for the large voluntary or municipal hospitals is a crying need in medicine to-day.\(^{121}\)

**Bath and Harrogate**

The CEC was also consulted on plans to revive the fortunes of the spas at Bath and Harrogate in the late 1930s. The problems once again related to a fixed list of available doctors in spa schemes to provide “all-in” packages for accommodation and treatment for the lower middle and working classes. These proposals were being put forward expressly to meet the problems of the lack of spa provision as a NHI benefit, as well as to try to revive the fortunes of these two towns.\(^{122}\) At a meeting attended by doctors from both spas, the CEC was asked to set out rules on the problems of advertising these schemes, especially since the Buxton scheme had been debarred from lay press advertising, and to advise them on the questions of “free choice of doctor” and the selection of the spa duty rota.\(^{123}\) The Committee resolved that consultations at the spa should be undertaken by local medical practitioners, not by whole time officers employed by the local spa authorities. Panels of practitioners working for fixed fees were allowed so long as eligibility was clearly defined, and no eligible doctors were prevented from joining the lists. These criteria were to be decided by a medical advisory committee of local doctors. Lastly “the imposition of an income limit although permissible, is not essential on ethical grounds”. The spa doctor should, with the patient’s consent, write back to the patient’s attending practitioner. Lastly lay press advertising was to be allowed so long as the local profession had decided, at a meeting called by the BMA, that the scheme was in the public interest.

\(^{118}\) CEC, 22.12.1936.  
\(^{119}\) Council, 20.1.1937.  
\(^{120}\) CEC, 7.6.1938.  
\(^{121}\) undated brochure for Buxton Clinic, in CMAC SA BMA D114.  
\(^{122}\) Correspondence between Dr. Geoffrey Holmes of Harrogate, Durand, and Anderson, 1937 - 8, in, CMAC SA BMA D105.  
\(^{123}\) CEC, 8.3.1938.
When the opinion of the CEC was relayed by Macrea, one of the Deputy Medical Secretaries, he said, "any local authority contravening the basic principles for the formation of such schemes would naturally forfeit the right of advertisement allowed and the co-operation of the local profession." The CEC, arguing from similar principles, had made two different sets of decisions on treatment schemes set up for "tariff rate" treatment of poorer patients in spa centres. The differences between them was that in Buxton the clinic was privately owned, and lay people were to select the doctors, whilst their proposals for the Local Authority run schemes in Bath and Harrogate were that the local BMA should set entry criteria for the list of available practitioners. It is striking that they assumed the latter process would be fair.

These larger schemes were coming into a market still characterised by many smaller clinics and hydros. One meeting of the CEC in 1936 considered an enquiry about a leaflet proposed for "patients ... and their friends" detailing the enquirer's "Anti-rheumatic clinic for persons of moderate means". They advised him that whilst it was "within the recognised custom of the profession" both to print material for patients and "to modify his usual fee in order to meet the economic circumstances of a patient" but this leaflet should not be distributed to non-patients. The committee ruled this was "objectionable" but indicated they would approve "a general statement that baths and other forms of treatment are available at the hydro under medical supervision."

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124 letter Macrea to Dr F I Dawson 24.3.1938, in D105.
125 CEC s/c, 11.2.1936.
supervision”. The practitioner was advised to disassociate himself from the hydro if his employers did not conform with this indication.\textsuperscript{126}

**The “Rheuma Spa of Wales”**

This so-called spa occupied Kinmel Hall, in North Wales: a converted school set in extensive grounds, which provided a set of more or less fashionable therapies in the surroundings of an expensive country hotel. Following the departure of their first medical officer, who darkly hinted at his “grave reasons” for leaving, the BMA made a few local enquiries about it. It was clear that the medical officer had not been allowed to supervise treatments, and the only trained nurse on the staff had been pushed out.\textsuperscript{127} A local GP told them the visiting consultants were evidently not aware of the way the place was being conducted, and “where the spa water is to come from I cannot think”.\textsuperscript{128} The CEC considered this information along with a brochure for the place which outlined the creature comforts and general facilities in great detail. It also featured the sunlight therapy room, the light diet room, facilities for hydrotherapy, electrotherapy, remedial exercise, including Zander machines, Pistany mud treatment, zotofoam baths, colonic irrigation and hormone treatment. The Committee objected to the claims that this rejuvenation package could help “100%” of patients feel “20 years younger”, to the listing of the medical practitioners engaged to provide various services, and to the styling of the proprietor’s husband, a doctor of music, as “Dr.”.\textsuperscript{129} They had also been told that the “whole idea is to get a man there to cover the employment of chiropractors, manipulators etc.”\textsuperscript{130} Advertisements for both the Spa and for a new medical officer were refused, and this induced the owner to approach the BMA for advice on the running and advertising of her therapeutic hotel.\textsuperscript{131}

**Discussion and summary**

The BMA’s deliberations on subjects related to advertising were enormously complex, at times incomprehensible, often contradictory, but evidently immensely important. From the simple rule that “a medical man should not advertise”, and its underlying principle that doctors should not behave like tradesmen or businessmen, flowed a whole set of cases and codifications that attempted to apply this idea to situations of great complexity. The ideal of professional non-advertisement

\textsuperscript{126} ibid.

\textsuperscript{127} Mills to Durand 16.11.1936 in CMAC SA BMA D127.

\textsuperscript{128} Memorandum, CEC 11.2.1936.

\textsuperscript{129} Brochure for Rheuma Spa, in CMAC SA BMA D128.

\textsuperscript{130} letter Durand to Anderson 17.9.1936, in CMAC SA BMA D127

\textsuperscript{131} See correspondence September 1936, Durand and Florence Lindley, in ibid.
was one that related to an (imagined?) world in which private medical practitioners built up their medical and material success through the virtuous development of their own excellence. Yet the marketplace in which they affected not to work was one which created and met a whole set of demands from the public for forms of healthcare that did not lend themselves to this model at all, at prices that could not really support it. What was more, this marketplace was crowded, not only with doctors, but also with a shifting cast of others, often chasing the same group of profitable clients.

Much work remains to be done to understand the complex world of more or less commercial therapy and the relationship between doctors, patients, lay therapists and lay proprietors in it. In their attempt to control and shape a whole heterogeneous category of therapeutic activity the BMA could only use relatively crude tools. These were advice to members, the sanction of advertising in the BMJ, and the disciplinary injunctions implicit in both their own resolutions and those they induced the GMC to issue. The power of these tools is evident in the way in which the Association was able to influence the organisation of some of these therapeutic concerns.

Yet, as we have seen, both the Association and the individual doctors that it represented were in business. No amount of arguing could shake them into a clear stance on advertising secret remedies (a huge contribution to the Association’s finances) or the advertising and financial arrangements found in nursing homes. They only moved decisively where lay ownership, the involvement of unqualified practitioners, public scrutiny, or any disruption of the three-way relationship between attending practitioners, patients, and consultants made it imperative. They also found themselves in great difficulty in convincing those practitioners who had gained sufficient social status and wealth to regard the rules as irrelevant that their compliance was vital. These doctors were an embodiment of the ideal of medical gentility yet they indulged in behaviours that the profession had designated as the hallmarks of trade and charlatanism.

The rules on advertising should not be viewed as simple rules concerning a specific activity, clearly argued from a set of moral or quasi-legal principles. Whilst they represented core professional values they were also interpreted with apparent inconsistency. More consistency was apparent in the BMA’s attempts to preserve the ‘space’ in which therapies and therapists, doctors and patients interacted and were evaluated on the basis of professional merit (whatever that might be), rather than commercial acumen, stridency of claim or conspicuous designations. The rules on advertising continued act as a defining boundary between this charmed space and the hustle outside, whilst also representing a strategy by which the profession attempted to engage profitably with the marketplace.
Chapter 11

Abortion, venereal disease and divorce

This chapter serves two different purposes. Firstly it is intended to set the scene for the issue of medical secrecy with which chapter 12 will deal. Deliberations on secrecy (which we now term confidentiality) were almost always connected with divorce, venereal disease and, most importantly, abortion. The second purpose is to explore the ambiguous place of abortion in the medical ethics of the period. The CEC received only one enquiry on the topic that was not primarily an enquiry about secrecy, and the topic received scant attention in texts on conduct. Discussions of abortion in early twentieth century medical ethics took place almost exclusively within discussions of secrecy. What was more, as I shall show, although abortion was stated by doctors to pose ethical, religious, societal and legal problems in the 1930s, it was not seen as a problem for medical ethics, nor indeed for the profession specifically. This chapter will thus initiate my discussion of the nature and role of medical ethics in the early twentieth century as well as outlining the shifting social attitudes underpinning controversies over secrecy.

Abortion

Abortion and “fertility control”

Abortion, as Barbara Brookes has pointed out, is “universally practised but by no means universally approved” and during the early twentieth century was seen as “a criminal act, a medical therapeutic procedure, and a popular method of fertility control.” Brookes argues that it was not until fertility control itself came to be seen a necessary part of healthcare for women that abortion could be discussed. Her work clearly shows that for most women, (that is, for working class women,) the concepts surrounding these areas were quite different to medical and legal frames of reference. Women did not consider themselves pregnant in the full sense until they became aware of the “quickening”, and up to that point, the disposal or loss of the foetus was often viewed as either expedient or trivial. Thus during this period there existed an endemic lay practice of securing regular menstrual flow - often by recourse to monthly purges, or, when “unusual delay” occurred, by the use of traditional means - soapy water douches, slippery elm twigs inserted into the cervix, or gunpowder and gin, or by proprietary medicines marketed for the purpose, such as ‘Widow

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Welch's female pills', Triumph, and Dr Reynold's 'Lightning Pills'. These were advertised as "restoring regularity" "removing obstructions" or for "female ailments". Whilst some methods were reasonably reliable, many of these cures were either noxious, ineffective, or both. Surgical or semi-surgical procedures were also carried out using either intra-uterine douches or instrumentation with such implements as skewers or knitting needles. There existed a continuum of abortion practice ranging from isolated and desperate self-inflicted measures, through informal lay networks of very amateur and low-charging "help", through more commercial remedies and systematic practitioners, some of whom were medically qualified.

Abortion and Law

Abortion law became stricter and more thorough after 1803 and the passing of "Lord Ellenborough's" Wounding and Maiming Bill. Before this abortion had been an offence under ecclesiastical law, which distinguished between attempts made before and after "quickening" (that is the perception of foetal movements by the pregnant woman), and only concerned itself with the fact of foeticide rather than intent to abort. It has been argued that the subsequent shift away from such lay concepts in abortion law was partly inspired by medical influences. Certainly abortion law increasingly employed the developing medical view of life before birth. Ellenborough's Bill, whose main purpose was to expedite convictions, shifted the offence from actual harm, to intent to produce abortion by use of poisons or instruments by third parties, but still kept the distinction of the "quickening"). The Act was amended in 1828 (when the use of instruments after quickening was banned) and in 1838 (when the distinction between attempts before and after quickening was removed, along with the death penalty attached to the crime).

The 1861 Offences Against the Person Act (OAPA) was the wide ranging and strict law which introduced the familiar concepts of grievous and actual bodily harm. In this law attempts at self-abortion along with supplying the means to do so, were criminalised, as were all methods of procuring abortion by third parties. Crucially however, the word "unlawfully" was used to define the crime, making its interpretation difficult. By the 1890s the Act was seen by some members of the judiciary as excessive in its sentencing. One of its critics, Mr Justice Darling, went on to

\[^{2}\textit{ibid.}, \text{pp. 1 - 6.}
\[^{3}\textit{Keown, J., Abortion, Doctors and the Law: some aspects of the regulation of abortion in England from 1803 - 1982,}
\text{Cambridge, CUP, 1988, p. 27.}
\[^{4}\textit{ibid.}, \text{pp. 3 - 22.}
\[^{5}\textit{ibid.}, \text{p. 43.}
\[^{6}\textit{ibid.}, \text{pp. 33 - 47.}
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support the Infant Life (Preservation Act) of 1929, which tightened the law further, as well as introducing a fresh anomaly. This law only allowed abortion on medical grounds after 28 weeks of pregnancy. Thus as the law stood by the 1930s when public debate on the question really started in earnest, a doctor could, legal texts stated, undertake an abortion to safeguard the life of the mother, but crucially the extent to which this was justifiable as "lawful" was left open. The new law made it possible to undertake the gruesome business of an abortion after 28 weeks to safeguard the life of the mother in more positive and watertight terms. The law overall, as Brookes shows, was not an effective deterrent, freely disregarded and variously interpreted as it was. ... the law operated to the advantage of those with money and professional status. ... An 'amateur' abortionist who induced abortion for a friend, lacked the justification of necessary 'treatment' which doctors could claim.

**Medical Abortion and Medical Ethics**

Percival dealt with the question of abortion in his chapter on medical jurisprudence where it was overshadowed by the discussion of infanticide, and other forms of homicide. He defined abortion as a form of murder, asserting that "the first spark of life" was as much part of "the ordinances of God" as an infant, child or man. Having said that, he also stated that abortions were justifiable in cases where pelvic delivery would be absolutely impossible. He alluded to its place in the Hippocratic Oath (which as an Edinburgh graduate he might have sworn), but noting the ineffectiveness of pessaries, cautioned the potential witness against assuming that a method employed could actually have been effective. Thus whilst Percival placed abortion on the same moral plane as murder, he stressed the distinction between intent and outcome. De Styrap's *Code* did not deal directly with abortion - despite being written shortly after the passing of the 1861 OAPA. Saundby, in a half-page section on "induction of premature labour", managed to summarise all the essential features of the medical ethics of termination of pregnancy over the coming half century. Abortion was, he said "a crime in all civilised and Christian countries",

... nevertheless it is well-known that medical practitioners more or less frequently undertake it ... There is reason to believe that some laxity exists in the principles of some members of the medical profession in regard to this question ... Danger to the health of the

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8 ibid., p. 23.
9 This is particularly interesting in the light of the sharp debate that existed in Manchester over the status of caesarean section, a debate which helped to trigger the writing of his *Code*. see: Pickstone, 'Thomas Percival and the production of Medical Ethics', in, Baker, et al. (eds.), *Medical morality, Vol I*, 1993, 161 - 178.
10 Percival, *Medical Ethics*, 1803, IV.x.
mother is held by some to justify interference; a rule which is capable of such a liberal interpretation than an inopportune pregnancy might always be carried upon this plea.

Thus he counselled, if considering such an option, a doctor should always get a second opinion. Termination could only be “sanctioned in the presence of grave danger to the life of the mother; and where the foetus is viable, the operation selected should be, wherever possible, one which may preserve both lives”.

Other guidance texts from the period simply repeat some or all of these points in more or less detail. Aitchison Robertson simply stated that a second opinion was needed to induce premature labour. In my reading through of the CEC Minutes from 1902 - 1939 I have found only one application for advice on abortion, in the 1902 - 03 session. The advice given was that it should only be undertaken on “purely surgical grounds, by those who in consultation see the case”. The subject was not found in the BMA Handbooks or in Sprigge’s Conduct of medical practice, but a 4 line rewording of the 1903 formulation was printed in the 1949 booklet Ethics and members of the medical profession.

Yet it is likely that doctors carried out abortion on a fairly wide scale, but rather like dichotomy, because all parties to the procedure were consenting it was unlikely that it would be discovered. Only an untoward death - the usual method of discovery of abortion - was likely to trigger a case. What is more, as we shall see, doctors were very reluctant to inform the authorities of cases of abortion, and could themselves issue death certificates. A few medical abortionists were tried and found guilty, but Brookes states that as the period progressed juries were increasingly reluctant to convict medical practitioners of the offence. Given that the GMC would have investigated any practitioner convicted of the offence we can take Smith’s figures as a reliable guide to the incidence of these convictions. Between 1902 and 1939 sixteen medical practitioners were referred to the GMC for abortion, all by the courts, and all of them were erased from the Register.

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11 Saundby, Medical ethics, 1907, p. 64.
12 CEC, 8.12.1903.
13 BMA, Ethics and members of the medical profession, 1949, p. 16. “Termination of pregnancy. This should be done on purely medical grounds and it is essential to obtain a confirmatory second opinion before recommending or undertaking such action.”

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Minty characterised "those found guilty of systematically assisting to procure miscarriages" as "unqualified nurses, quack doctors and Indian practitioners", but it hard to take him seriously when he referred to ridiculous stories circulated largely by medical students about general practitioners working in league with gynaecologists who for a fee of 10 guineas will state that in their opinion an artificial abortion is necessary, and that handsomely furnished nursing homes exist in order to relieve society belles of the consequences of their indiscretions. The supposition that such a state of affairs could exist in England is too ridiculous to think about.¹⁵

Cronin, writing only a few years later, but for different polemic purposes, put these words in the mouth of a disgruntled West End doctor, “I’m about sick of Ivory’s bloody side. He’s no surgeon, you’re damned well right. He’s nothing but a damned abortionist. You didn’t know that, eh? There’s a couple of nursing homes not a hundred miles from this house where they do nothing else.”¹⁶ The case of Dr Laura Sanders-Bliss, prosecuted and struck off in 1936 for carrying out numerous abortions, in a practice that used a Harley Street address and a country nursing home, demonstrated that Cronin’s account is the more likely to be accurate.¹⁷ An earlier case, of Dr Devi Sasun, an East End Panel practitioner who carried out abortions for remarkably low fees demonstrates that the operation would also have been affordable for the middle and lower middle classes too.¹⁸ Whatever the prevalence of the medical procedure itself, it is obvious that doctors were frequently asked to help procure abortions. “The general practitioner”, le Fleming observed, “is not infrequently asked by a woman, married or unmarried, to procure an abortion for reasons of convenience.... there can only be one answer to such a request. ... the doctor will find it most easy to shelter his refusal behind the necessity for consultation.”¹⁹ This quotation demonstrates the importance of the “consultation” component of the advice given by Saundby and the CEC, but also only discusses “reasons of convenience”. The ambiguity of the OAPA’s use of the term “unlawfully” meant that there the question of what constituted a reasonable request was left open.

Abortion in the 1930s

The subject of abortion was increasingly discussed and debated in the 1930s. Brookes shows that a number of medical and social trends were making themselves felt, leading different people to draw

¹⁸ *Ibid.*, p. 35. Sasun charged 5 - 10 guineas, as against a more usual charge of 50 - 70 (often split with a nurse or nursing home.)
opposing views on abortion. The key anxieties were “over the family, sexuality, secularism, the birth rate and shifting gender roles”. The declining birth rates and childhood mortality focused attention more and more on the pregnant mother, and it was increasingly thought that the sequelae of failed or past abortions were responsible for around 10% of maternal mortality. The campaign for birth control had fundamentally opened up and shifted middle class attitudes to fertility control, and separated the issues of contraception and abortion.

The debate was opened up during 1932 by a series of comments and judgements made by Mr Justice McCardie. McCardie, who held progressive eugenicist views on sterilisation, abortion, and contraception, repeatedly made the point that birth control through contraception should be available, so that the legitimate, responsible desire to limit family size should no longer lead to the criminal act of abortion. Speaking of his own times as “an era of savagery” he stated,

> those who seek to uphold and administer the present law of abortion are wholly ignorant of the social problems which not only exist in our midst, but which menace the nation at the present time ... I cannot think that it is right that a woman should be forced to bear a child against her will ...

Yet, as a meeting of the Medico-legal Society in 1932 showed, whilst legal speakers tended to favour a modification of the law, the doctors who spoke generally regarded any change in the law as undesirable. There was certainly no enthusiasm for legalisation on the scale seen, and widely debated, in Russia.

It is worth looking at the arguments put forward in print by medical men during the 1930s. A book by a quartet of gynaecologists from London’s Chelsea Hospital for Women, with the striking title *Sex ethics*, attempted to reframe abortion, contraception and sterilisation within a system of ethics built up from ideas of biological naturalness and eugenicist arguments, and to indicate clearly where the law allowed action, and to what extent. They wanted, in the case of abortion to set out very clear-cut medical indications for abortion, which they did with great precision, and to disallow any thoughts of abortion for “sympathetic” reasons. (Sympathy, that is, with the woman’s request.)

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21 Brookes, p. 38
24 ibid., Chapter V.
Their aim was to demolish vestigial religious and generic moral objections and to replace them with a set of biologically ethical criteria,

leaders of religious thought and the makers of the laws ... [are] hampering the progress of medical activity in some of the most urgent problems of the present day. The problems of sex-relations, of race-restriction on economic grounds, of race-improvement by selective parenthood and the sterilization of the unfit, and the preservation of female life by therapeutic termination of pregnancy when definitely indicated, are all closely interlinked. ... the Church and the State [are] lagging behind, and failing to lift the cloak of secrecy and immorality from sexual intercourse and contraception, the criminal taint from therapeutic abortion, and the imaginary stigma of mutilation from sterilisation.^^

They also sought to provide an “authoritative pronouncement” for the guidance of doctors who were, under this “cloak of secrecy”,

each ... a law unto himself, for want of clearer guidance. The attitude of the many is this: they feel that abortion may be desirable in certain cases and, because there are no definite medical rules laid down, they are too apt to allow the desirability to be magnified into a necessity.

They went on, “the channel of therapeutic abortion lies between the shore of extreme regard to religion and the law, on the one hand, and sympathy and dishonesty on the other”.

The refusal of abortion was less easy for GPs, who established longer term relationships with patients and their families. This is apparent in Harry Roberts’ contribution to a “symposium” on abortion. In this volume Stella Browne called for women to be able to exercise free choice over their bodies as part of sexual liberation, and Ludovici castigated women who had abortions as “masculinoid”. In such company Roberts took on a studied ‘middle ground position’ in which he voiced nearly every conceivable relativism before committing himself to advocating social change to obviate the “terrible choice” of women, rather than relaxation of the law on abortion. His piece was an exposition of the mixed feelings of general practitioners when faced with requests for abortion from patients they knew well. It is also vital to the theme of this chapter, and thesis, since he contrasted generic feelings of sympathy and notions of right and wrong with laws, rules and medical ethics. “In a doctor’s daily work,” he said, “ninety-nine times out of a hundred, natural impulses and the sense of professional duty coincide. ... But there are occasions when his country’s

25 ibid., p. vi.
26 ibid., p. 147.
laws and the rules of his profession forbid a doctor to do to his patients as he would be done by.”

Some doctors,

willingly accept as final the orders sanctioned by the cardinals of the profession. Others ... have more difficulty with their conscience ... I am not talking about medical ethics; these are simply trade union or guild regulations - mostly sound enough and rarely involving anything more profound than the pocket. Few of these rules need ruffle the conscience of anyone.

He went on,

I doubt if many doctors of the younger generation today believe, in the bottom of their hearts, that in itself the performance of this operation is always in all circumstances an evil act. General rules are apt to lose some of their convincingness when they have to be applied to individual circumstances ... I never feel a greater coward than when I try to smother my conscience with blather about Acts of Parliament and mere conventions of right and wrong.

Like many in the abortion debate, Roberts was keen to portray the mores enshrined in the law as “conventions” not “truths”, and used ideas of generic spirituality, eugenics, naturalness, and the ambiguity of right and wrong in individual cases. What all but the most radical writers like Browne agreed on was that reform must be cautious and slight.

**The BMA Abortion Committee**

The increasing public discussion of the problem of abortion led to the matter being raised at the ARMs of 1932 and 1933. At the ARM of 1932 it was proposed that the Association pronounce on abortion law, but no action was taken. Representatives at the 1933 meeting said that the risk of prosecution was preventing medical men performing abortions even in cases with clear medical indications, and that “the medical profession should endeavour to guide public opinion, which was becoming more and more interested in question of abortion, birth control and sexology”. The meeting asked Council to “consider and report on the desirability of setting up the committee foreshadowed [in] ... 1932, on the law relating to abortion”.  

28 Roberts, Harry, “This Problem of Deliberate Abortion”, in, ibid., pp.122-3  
29 *ibid.*  
30 *ibid.*, p. 123  
32 ARM 1933, minute 22.
The Council's response to this was negative. They argued that there was no legal ambiguity where the mother's life was at risk and, most significantly that, "the profession is not competent to pronounce upon a problem which involves social, moral, ethical, economic and religious considerations". The Council did not want to fund an extensive review of law and social relations that would involve legal, clerical, public and political representatives. What was more,

It appeared to the Council after consideration that the medical interest in abortion was ... limited to the assertion of the freedom of the practitioner - preferably after consultation with a colleague - to induce abortion when the life of preservation of the health of the mother is deemed to require it, and that other relations of abortion were to the criminal law, and to social, economic, ethical and religious standards and opinions.\(^{33}\)

Faced with this finely argued cavil from the Council the ARM of 1934 elected to drop the idea of a committee on abortion law, but asked a committee to consider "the medical aspects of abortion."

The single most important point that can be made about this committee, (the CMAA), for the purposes of our discussion, is that it was not a sub-committee of the CEC, and only two current CEC members A L Hatch, and N Bishop Harman were elected to it. Ewen Maclean, ex-member of the CEC, and its chair for one year in 1910, was also on the committee in his capacity as a leading consultant gynaecologist.\(^{34}\) The CMAA met 7 times over the period November 1934 - April 1935\(^{35}\) but,

Having regard to the circumstances in which it was appointed, the committee decided to omit from its survey such matters as the technique of inducing abortion. It has also regarded abstract and specific questions of economics, equity, morality, and religion as being outside the scope of its inquiry.\(^{36}\)

Thus the bulk of their published Report rehearsed the medical indications for therapeutic abortion, but in marked contrast to the authors of Sex ethics, and partly on the urging of Aleck Bourne, they included psychological damage arising from continued pregnancy in girls under 16 and rape victims as possible medical indications.\(^{37}\)

\(^{32}\) ibid.

\(^{34}\) The other members were James Young (chairman), T W Naylor Barlow, Aleck W Bourne, Sydney Smith and Dorothea Walpole.

\(^{35}\) Medical Aspects of Abortion Committee - Documents, 1934 - 35, BMA A B/115/1/1


\(^{37}\) Aleck Bourne, memorandum, CMAA, 29.1.1935.
In fact the committee did comment on law reform. They had considered memoranda from the eugenist C P Blacker and abortion law reformer Stella Browne, as well as the technical medical submissions. They “strongly” recommended “not only the clarification of the legal position, but also the institution of some system of authorization of abortion in the individual case.” They were in favour of some form of official certification, with at least one signing doctor being “approved” for the purpose, to prevent collusion. Further they argued that “increase in the bona fide practice would result in the diminution of the secret procedure”, and that legalisation would go a long way to solving the problem. In the meantime however, doctors should be encouraged to expose the identities of abortionists (see the next chapter) and that “avoidance of pregnancy [note that the word contraception was not used] is the more rational plan”.  

Abortion, doctors and ethics

Why was abortion not more often discussed as a topic in its own right in texts and deliberations of medical ethics? To modern eyes it is a medical ethical problem par excellence. French used the example of abortion in his excellent problematisation of the historiography of medical ethics, yet it would be wrong to describe early twentieth century Britain as a time and place in which “abortion provided no ethical problems”. Indeed it was the growing conviction that considerations of eugenics, social wellbeing, maternal health and justice should also have a place in society’s response to unwanted pregnancy, as well as the availability of the techniques of contraception, that moved abortion as a subject out from under the shadow of a legal and religious hegemony into the light (and heat) of a wider debate.

Yet for the professionals called upon to perform abortions, and thus at legal and social risk, it was dangerous to appear too partisan in this debate, and the positions adopted by doctors when debate began were relatively conservative. Doctors were advised to use “consultation” as a way out of requests for abortion on non-medical grounds, and the BMA shied away from sponsoring a debate on the issues. The BMA’s abortion committee, having not set out to consider law, could then make comments on it as ‘asides’. Again the idea of consultation was paramount. Almost all medical contributors to this debate supported a type of certification which recorded the outcome of a consultation process. The BMA was not prepared to take the lead, regarding the general ethical, moral and religious components of the problem as beyond their jurisdiction.

38 ibid, p. 24.
39 ibid, p. 25.
When the law was further clarified, it was by CMAA member Aleck Bourne. Bourne deliberately aborted an under-age rape victim in 1938 (thus conflating two of the categories he was arguing for) presented himself for arrest, and had his actions endorsed in Court. Whilst this set a precedent for well-qualified doctors acting in consultation with each other, it did nothing to help the overwhelming majority of practitioners faced with the huge numbers of patients with unwanted pregnancies. The 1968 Abortion Act put in place a system that relied on the opinion of two doctors to confirm the necessity of the operation, one of whom could be the patient's own doctor. GPs no longer had to "hide" behind the need for consultation; society had accepted consultation as a valid method of adjudicating the appropriateness of abortion.

Medical ethics did not deal with what lay beyond the law (on the principle that Saundby characterised as "rendering unto Caesar") but with what lay within law, but outside generic social codes and mores. The behaviour of doctors was guided by their own generic ethical and moral views, and their relationship to the law. Where they felt abortion might be justifiable, they could use the medical conduct device of sharing the decision with another doctor. This was a dialectic between society, law, and medicine in which doctors protected their social position by locating the general ethical debate outside their own jurisdiction, whilst continuing to make judgements in individual cases which could involve the theoretical risk of censure or prosecution.

**Venereal Disease**

Venereal disease denotes the collection of conditions communicated primarily through sexual contact including syphilis, gonorrhoea and chancroid. During the nineteenth century VD had come to be seen as a number of distinct conditions, and medical writing on the subject was to become steadily more sober and moralistic. These conditions were frequently treated by unqualified practitioners, or by mail order; systems that offered "secrecy, rapid cure at moderate expense (even "No charge unless cured"), and without mercury". The wide range of more or less unpleasant treatments of limited effectiveness, combined with the social taint of the patient with VD, both caused and were exacerbated by the almost complete absence of research and education in VD. The Contagious Diseases Acts of 1864, 1866 and 1869, which were repealed in 1886 were essentially...

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attempts to control the spread of VD among troops by controlling prostitutes in a specific series of garrison towns. Suspected prostitutes could be arrested, examined and if “infected” forcibly hospitalised until “cured”. In Glasgow and other cities, prostitutes were “rescued” by institutions that also “treated” any venereal disease disclosed at compulsory examination. Voluntary hospitals and friendly societies would refuse to treat venereal disease, and “medical practitioners shrank from private practice in venereology, profitable though it was”.

Several factors combined to prompt the formation of the 1913 - 1916 Royal Commission on VD chaired by Lord Sydenham. Not only were many social and medical problems reconstrued as impediments to national physical well-being, but diagnostic tests and moderately effective treatments for syphilis, (in the form of Salvarsan developed in 1909,) had become available. The Commission estimated that syphilis and gonorrhoea were extremely common in urban populations, that new methods of treatment and detection had not been widely taken up, that quacks and unregistered practitioners often dealt with VD, and concluded that only the State could adequately deal with the problem. The system of free, voluntary-attendance and confidential clinics recommended by the Commission were brought into being under Statutory Orders, “Regulations” under existing Public Health legislation, and further bolstered by measures in the Venereal Diseases Act of 1917, which made the unregistered treatment and advertisement of VD cures illegal.

These liberal reforms took place against a backdrop of very much more slowly changing public and medical attitudes to these diseases. Mark Harrison has demonstrated the confusion of moral and medical attitudes under the rubric of military discipline in the British military during the First World War. After the War, a policy of health education without provision of antiseptic prophylactic packets was pursued by the NCCVD, set up out of the Royal Commission. They did this despite evidence that, along with free clinics, “prophylactics” would do a great deal to reduce VD. The policy was resisted for moral and political reasons. The nascent Ministry of Health would not take the risk of backing the medically more effective, but politically more difficult prophylaxis

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46 ibid., p. 318.
approach, or even adjudicate the question effectively. The emerging speciality of venereology remained a stigmatised and marginal subject, "the Cinderella of medicine" despite the paraphernalia of a Medical Society for the Study of Venereal Diseases and the foundation of a Journal of Venereology (1925). In fact, venereal diseases, particularly syphilis continued to decline during the interwar years, quite probably due to the success of the clinic system, but their final "conquest" had to await the availability of penicillin during the Second World War. In 1931 Crookshank saw no less need to try and persuade general medical readers that the venereal diseases were a medical not a moral category than he had in 1921.

For the purposes of this study, the main points to draw from this story are that despite the public moral abhorrence of venereal diseases shared by many doctors, the successful public policy put in place to combat them was a close parallel to several features of the private practice system; attendance was voluntary, and information confidential. Despite these parallels, private practice itself, when it had faced huge commercial and non-registered competitors, had failed to meet the needs of the population suffering from VD. Both points needed constant defence it seems. We have seen how fiercely the profession fought for voluntary "free choice of doctor" in medicine, and in the next chapter we shall see how deep feelings about confidentiality ran.

**Divorce Law**

As with abortion, the story of divorce begins with Ecclesiastical Canon Law. This held that whilst marriages could be instantly and indissolubly made, even by a simple declaration between lovers, there were also vast numbers of "impediments" which if proven allowed effective divorce a mensa et thoro ("from bed and board"). In contrast to Scotland, where the Post-Reformation law quickly established new grounds for divorce, in England the canon law code was essentially preserved, but "without the very evasions, fictions and loopholes which had made the mediaeval system tolerable in practice". The mediaeval grounds for divorce, the matrimonial "causes" themselves were not altered between 1697 and 1923, and not substantially until the 1937 Matrimonial Causes Act (MCA). Not only this, divorce was only very slowly made available to classes other than the aristocracy, and was not effectively within the reach of most working class people until the advent of Legal Aid in 1951.

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50 Hall, 'Cinderella of Medicine', 1993, pp. 317 - 318.


Prior to 1857 divorce could only be obtained by an Act of Parliament, and was thus, in common
with Acts of Enclosure, a mechanism whereby the upper classes could ensure the disposition of
property (in this instance where marriages had absolutely failed). "For practical purposes",
McGregor concludes, "the Private Act procedure could be invoked only by men whose wives were
adulterous".\(^{53}\) Although after 1775 this procedure was brought under a set of standing orders, it was
still hugely expensive and time-consuming. When the question of the divorce came under scrutiny
of a Royal Commission in 1850 it was found that divorce cost £800 in England, against £30 in
Scotland. However, the Commission's recommendations, enshrined in the 1857 MCA, were
avowedly not an extension of the "causes" but simply provided better procedures, through the
establishment of a Divorce Court in London, and the abolition of the ecclesiastical stage. The
"causes" were adultery, cruelty of either spouse, or desertion without cause for two or more years.
However, the husband had only to prove adultery, whilst the wife had to prove that plus either
desertion, cruelty, incest, rape, sodomy or bestiality. Proven connivance, condonation or collusion
invalidated divorce applications.\(^{54}\) Thus divorce law enshrined the inequalities between sexes and
classes.

The exclusion of the working class was to become a scandal with the public exposure of the extent
of wife-beating and wife-murder in some districts in the 1870s - particularly Liverpool's "kicking
district" where 170 women were beaten to death in 1874. Campaigning by Frances Power Cobbe
culminated in the passage of the 1878 MCA which allowed magistrates courts to grant separation
orders and maintenance payments. In the period 1897 - 1906 87,000 such orders were made.\(^{55}\) At
roughly the same period Divorces had quadrupled from their mid-century average.\(^{56}\) A Royal
Commission considered the divorce system between 1909 and 1912. This system had been
described by Lord Gorrell in 1906 as being full of "inconsistencies, anomalies and inequalities
almost amounting to absurdities". The commission noted that equally "learned ... able ... pious ...
and honest" people held mutually exclusive views, an observation which explains why the
recommendation of its majority report sank in a storm of controversy.

Small, but for our purposes highly significant, changes were made in the 1920s, and in the years
following the First World War the number of divorce cases nearly tripled. The availability of

\(^{53}\) ibid., p. 11.
\(^{54}\) ibid., pp. 17 - 18.
\(^{55}\) ibid., pp. 20 - 24.
\(^{56}\) ibid., p. 19.
divorce proceedings outside London Divorce Courts originally envisaged in 1857, long resisted by
the judiciary, was finally introduced in 1920. Thereafter poorer people's cases and undefended
cases could be heard in Assize towns, (and such hearings constituted nearly half all divorce
proceedings by 1936) much to the displeasure of their Lordships. McGregor, aside from providing
an undated quote of disgruntlement from a judge, gives no details of how this reform was achieved
and whether any allowances were made for it in the organisation of the Quarterly Assizes. The fact
that after 1946 Special Commissioners were appointed to allow the Judges to deal with more
weighty matters suggests that this reform had simply added to their Circuit work. The other change
introduced in 1928 (significantly following the extension of the franchise to many women) was the
equalisation of the 'matrimonial causes' between sexes. Like the 1920 organisational extension of
court provision, its effect can be discerned in the figures given in Table 11.

Table 12: the rise in petitions for divorce in England, 1896 - 1950

<table>
<thead>
<tr>
<th>notes</th>
<th>period</th>
<th>average yearly petitions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1896 - 1900</td>
<td>675</td>
</tr>
<tr>
<td></td>
<td>1901 - 1905</td>
<td>812</td>
</tr>
<tr>
<td></td>
<td>1906 - 1910</td>
<td>809</td>
</tr>
<tr>
<td></td>
<td>1911 - 1915</td>
<td>1,033</td>
</tr>
<tr>
<td>provincial divorce available</td>
<td>1916 - 1920</td>
<td>2,954</td>
</tr>
<tr>
<td></td>
<td>1921 - 1925</td>
<td>2,848</td>
</tr>
<tr>
<td>1928 MCA (equalised causes)</td>
<td>1926 - 1930</td>
<td>4,052</td>
</tr>
<tr>
<td></td>
<td>1931 - 1935</td>
<td>4,784</td>
</tr>
<tr>
<td>1937 MCA (extended causes)</td>
<td>1936 - 1940</td>
<td>7,535</td>
</tr>
<tr>
<td></td>
<td>1941 - 1945</td>
<td>16,075</td>
</tr>
<tr>
<td>legal aid (Working Class inclusion) and 2WW</td>
<td>1946 - 1950</td>
<td>38,901</td>
</tr>
</tbody>
</table>

All this would simply make interesting social history of no direct consequence to medical ethics
were it not for the fact that a doctor's knowledge of the presence of VD in one or other partner
could prove either adultery, and or cruelty in passing it on. As the divorce system came under
increasing strain in the 1920s it appears that judges turned to medical evidence to help speed
through divorce hearings and in the process offended medical codes of secrecy. This set of
matrimonial causes however were only mildly 'medical' compared with those brought in by Alan
Herbert's MCA of 1937 (the first extension since 1697). The causes applying after 3 years
marriage were adultery; 3 years desertion; cruelty; and being "incurably of unsound mind ...
continuously under care and treatment ... for at least five years". The wife could also claim against
her husband for rape, sodomy or bestiality. Causes applying within a year of marriage involved still

57 from ibid., p. 36.
more medical information, being deliberate non-consummation; being at time of marriage either
epileptic or of unsound mind; suffering at time of marriage from communicable VD; or pregnancy
by another man at the time of marriage”.

Thus, as social attitudes to marriage slowly translated into divorce law and legal access reforms.
British marriages ended in an exponentially rising number of divorces in which medical evidence
was increasingly required to establish proof of the matrimonial causes.
Chapter 12

Professional secrecy: “Should the doctor tell?”

Introduction

Charles Hawthorne, writing some years after the main dispute set out in this chapter, stated that

frankness on the part of the patient and silence on the part of the doctor are essential conditions of medical practice. Clearly it would be a most dishonourable action for a doctor to reveal what he learns of a patient’s affairs in the secrecy of a professional interview, and a talkative doctor, if one can be imagined, would be a social nuisance and a mischief maker.1

Aitchison Robertson, writing earlier, struck a similar note when he said, “to anyone of true gentlemanly feeling the giving away of a confidence is repellent”.2 For him secrecy was “the first commandment of medical ethics” and one of the foundations of the “very close and intimate relationship between doctor and patient.”3 Despite the fact that none of the protagonists in the debates on secrecy would have disagreed with them, this issue was to arouse more passion than perhaps any other issue examined thus far.

During the period 1915 - 1924 the BMA clashed first with the Lord Chief Justice, and later with the judiciary over the issue of disclosure of clinical information to the authorities and in courts of law. The members of the profession who took the lead in this debate wanted to defend the right of doctors to reveal only what their patients had consented to have divulged. They argued that doctors should have complete “privilege” to prevent this principle being overridden by Courts of Law. The legal profession took the view that this would not only act to undermine legal processes, and was thus against the public interest, but would undermine the medical profession’s own ability to defend itself at law. But the doctors who took up the cudgels on this issue do not appear to have been prepared to see it as anything other than a matter of professional honour, and their action was for them a defence of the profession’s “ancient”, “sacred” and “traditional” moral code. Such language is, of course, a red rag to a historian, and the deployment of ‘Hippocrates’ in this dispute signifies more about England in the 1920s than Kos in the 4th century BCE. ‘Hippocrates’ was one of the

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1 Hawthorne, ‘Medical Ethics’, 1936, 646 - 56.
2 Robertson, Medical conduct and practice, 1921, p. 32.
3 ibid., p. 132.
“big guns” brought up by those who saw this dispute as a fight to redress an imbalance in power and status between Medicine and Law. They did not notice, it seems, that the gun could be trained just as effectively on their own position.

Many of these doctors were acutely anxious about public opinion and confidence. One of the reasons for this was the sensitivity of much of the information they imagined they were to be called on routinely to reveal. In almost every case, the debate was triggered by matters involving extramarital sexual activity. Doctors were heavily involved in the sequelae of such activity. Unwanted pregnancies might be aborted, either by doctors or lay people, and doctors called on to treat its complications, or the pregnancy could be concealed, and the baby abandoned or given up. In this latter situation the police often requested information that might lead to an arrest. Heads of households might wish to know if their servants were “in trouble”. Venereal disease contracted by one partner within either an established or proposed marriage was another instance where doctors were privy to secrets arising out of sexual impropriety. This latter situation was one in which both infidelity and cruelty could be neatly proved in divorce cases.

The dispute over professional secrecy both inside and outside the BMA changed very little in fact. What was worse, individual doctors frequently failed to apply the strict rules that some of their leaders and representatives had fought so hard to defend. Before setting out the two main disputes over secrecy I shall examine the development of legal and medical ethical thinking on the question.

Confidentiality in medical ethics and law before 1915

Hippocrates, Percival and the Duchess of Kingston

Secrecy was one of the undertakings of practitioners who swore the Hippocratic Oath, and it seems reasonable to assume that the original reasons for including this principle in the Oath were analogous to the thinking apparent in Hawthorne’s formulation, quoted earlier. One can certainly state that doctors in the nineteenth and twentieth centuries saw the implicit contract of confidentiality in medicine as important, whether or not they regarded it as derived from Hippocrates. None of the medical protagonists in the events described here were aware of the comments made in the Decorum to the effect that gossiping would result in lay criticism of treatment.4 Yet this seems the best approach to the injunction in the Oath, which did not imply

4 It was noted by one legal commentator, in, Riddell, George Allardyce Baron, (Lord Riddell), 'Should a Doctor Tell?', *John O’London’s Weekly*, XVII: July 16, 1927, pp 441 - 443.
absolute secrecy at all. It stated, "whatever I see or hear, professionally or privately, which ought not to be divulged, I will keep secret and tell no one."5 Indeed the whole debate over secrecy could be characterised by an argument about what ought and ought not to be "divulged".

Percival, the putative ‘father of medical ethics’ was able to write on tact, confidentiality and the duty to give evidence in court without reference to the supposed “father of medicine”. Secrecy was dealt with in a few direct comments in Percival’s code. Interviews in hospital, he said, should be conducted quietly, so as not to be overheard, and “secrecy, also, when required by peculiar circumstances, should be strictly observed.”6 In private general practice he repeated this advice and added “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.”7

Percival’s general attitude to the law, even though he said nothing about secrecy in the courts as such, is worth examining here. In Chapter Four he discussed such matters as the importance of medical evidence in establishing rape and infanticide.8 He also addressed coroners’ and magistrates’ complaints that doctors “are often reluctant in the performance of the offices required of them as citizens ... to aid the public justice”. These duties were to Percival “appropriate debts to the community” even if they were inconvenient.9 He also stressed the need to tell the truth under oath, “sacrificing personal emotions”, even where capital punishment for the defendant was at stake, arguing that the overriding duty was to society, and pointing out that if doctors withheld evidence they were “an accessory to all the evils which ensue”.10

Percival did not mention a case, heard in 1776, that set the prime legal precedent on the doctor’s duty to testify, but given the tone of his general comments it seems very unlikely he would have disagreed with the principle it established. The Duchess of Kingston was tried for bigamy before the House of Lords, and Mr. Caesar Hawkins, sergeant-surgeon to the King was asked if he knew of any marriage between her and the Earl of Bristol. He answered, "I do not know how far anything that has come before me in a confidential trust in my profession should be disclosed consistent with

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7 *ibid.*, II.i.
8 *ibid.*, IV.xvi
9 *ibid.*, IV.xviii
10 *ibid.*, IV.xix
my professional honour”. Lord Mansfield, presiding overruled this request to keep confidences saying

a surgeon has no privilege to avoid giving evidence in a Court of justice, but is bound by the law of the land to do it... If a surgeon was voluntarily to reveal those secrets. To be sure he would be guilty of a breach of honour and of a great indiscretion; but to give that information in a Court of justice, which by the law of the land he is bound to do, will never be imputed to him as any indiscretion whatever."

This statement was quoted by all who discussed the issue as establishing a precedent that doctors should give evidence if directed by a judge - even if they disagreed with this ruling.

However, De Stryrap writing, in the late nineteenth century, emphasised legal respect for the medical tradition of secrecy. Explaining that the obligation of secrecy extended even “beyond the period of professional services ... unless imperatively required” he stated “the force and imperative of this obligation are indeed so great that professional men have, under certain circumstances, been protected in their observance of secrecy by courts of justice”. He also set out many ordinary circumstances that justified the breaking of secrecy, albeit with tact. “Delicacy,” he said, “must in all cases be strictly observed, and secrecy also, under all but very exceptional circumstances - as for instance, in a case of threatening insanity, or of pertinacious concealment of pregnancy after seduction, in which it would probably be the practitioner’s duty to communicate his fears to a near and prudent relative.”

Conflicting opinions (1896 - 1907)

Medical confidence in social and legal endorsement of professional secrecy was confirmed by a case that had alarmed the profession in other respects. The Kitson Playfair action for slander culminated in the award of £12,000 pounds in damages against an eminent member of the RCP with an extensive gynaecology and obstetrics practice. Linda Kitson, his niece, suffered a miscarriage more than a year after last seeing her estranged husband, a fact established when Playfair found placental tissue when examining her under anaesthetic. He interpreted this as evidence of “hanky-panky”, and informed his wife, who informed her brother, Kitson’s father in-law, who cut off her

12 De Stryrap, Medical ethics, 1890, p. 40.
13 ibid., p. 39.
allowance. The prosecution successfully portrayed Kitson as the victim of Playfair’s villainous blackmailing and exposed inconsistencies in medical witnesses’ evidence and attitudes.14

The case had hinged on whether or not communications between husband and wife were “privileged”, and in discussing this question medical witnesses had stated that they might consider revealing to the authorities the fact that a woman was suffering the after-effects of an illegal abortion. Mr Justice Hawkins (later Lord Brampton) alluded to a “poor wretched woman” undergoing abortion as the only means of “saving her character, ... reputation, and ... her very means of livelihood”. He commented that he “doubted very much” if a doctor called to help her afterwards “would be justified in ... going to the Public Prosecutor ... a thing like that would be a monstrous cruelty”.15

Angus McLaren has written very usefully on this case, drawing out the confusion in doctors’ thinking on confidentiality: confusion largely caused by the intrusion of moral, class and gender attitudes into their thinking on the principle of secrecy. He demonstrates for instance that male confidences were far more likely to be respected than female, and those of the upper and middle classes than the working classes.16 Where McLaren’s analysis is less helpful is in his assertion that the trial “played an important role in establishing a clearer definition of doctors duties as regards confidentiality”. It could be argued that the opposite was the case. Lord Brampton’s comments were widely (and mistakenly) cited as an authoritative legal precedent on the issue of secrecy generally, and on the issue of informing the authorities on abortions specifically. A later legal writer stated this categorically, saying “the case ... is not really relevant as the action was for slander and not for breach of confidence.”17

Following this case, the RCP, “at the instance of Dr Francis Champneys” set out to “define in a legal sense the proper conduct of a practitioner brought into relation with a case of acknowledged or suspected abortion”.18 They obtained a legal opinion from Mr. (later Sir) Edward Clarke and Mr (later Sir) Horace Avory. This opinion, like the statement of Lord Brampton, was to be contested later. The Report was pronounced secretum collegii, but interest in it lead to two much deplored

15 Saundby, Medical ethics, 1907, p.112.
17 Kitchin, Law for the Medical Practitioner, 1941, p. 54.


‘leaks’. Discussing the problems of informing on abortion and confidentiality there was, they said “no privilege attaching to statements made to a Medical Practitioner by a patient.” In response to the question “What is the duty of a medical practitioner who knows or who believes he is in attendance in a case in which criminal abortion has been practised?”, their reply was, “... it is the duty of the medical practitioner ... to attend his patient to the best of his skill, and he does not thereby render himself an accessory after the fact, so long as he does nothing to assist the patient in escaping or defeating justice”. The concluding general comments added that “the duty of the medical practitioner as to giving information in particular cases ... must ... be exercised according to his discretion”.

Saundby, writing on secrecy in 1907, described a disputed area, in which the legal profession and the courts loomed large. His formulation, balancing the obligations of the doctors against the power of the courts remained essentially accurate despite all that was to follow. Although lacking full “privilege,” he said, “a medical practitioner is under an obligation to his patient to preserve his secrets, and in legal matters should, except with the patient’s consent, answer questions only at the express direction of the judge”, and should never volunteer such information. Here we see a vital component of the secrecy debate not previously mentioned, the need for consent to revelation. His main contention was that it was “ethically wrong” to volunteer information without it.

Saundby contextualised, and rationalised, the lack of absolute legal privilege accorded to medical confidences in Britain, turning first to the example of France where this concept was enshrined in law. This system, he argued, led to injustices on all sides: a doctor who knew information that would bring a criminal to justice was barred from revealing it. Even where patients had consented to the use of confidential information, the police might still prosecute the doctor for breaking the law. There might, he said, “be cases where it was the obvious duty of the medical man to speak out”, and gave the example of a wounded murderer seeking treatment. In other respects though, Saundby’s views were strict. In his discussion of the sale of practices, for instance, he stated that casebooks and patients records should not be sold with the practice, since this would breach

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19 The contents of the College report were revealed in *The Scalpel*, 1896, i: p. 160 by “MRCP”, in a letter to *Medical Press*, 1896, i: p. 591. The BMA were able to obtain a copy in 1915.

20 Opinion of Counsel, CEC 8.1.1915, in CMAC SA BMA D170.

21 Saundby, Robert, *Medical ethics, a guide to professional conduct*, (2nd edn.), London, Charles Griffin, 1907, p. 111

22 ibid., p. 112.

23 ibid., p.113.
confidentiality. Neither did he feel doctors were bound to volunteer information in cases where babies had been found abandoned.  

His comments included an account of the Playfair trail and Lord Brampton’s statement, and he also, as an FRCP, took the risk of discussing the leaked “secret” College report on Abortion. He summarised it as being “to the effect that a medical man should not reveal facts which had come to his knowledge in the course of his professional duties, even in so extreme a case as where there were grounds to suspect that a criminal offence had been committed.”

It is worth setting this against the actual Opinion quoted above, since this was a contested point later on. Clarke and Avory certainly did not say that a doctor had an absolute obligation to inform, rather that whilst their primary duty was medical care, they must not pervert the course of justice, and that any decision to inform authorities had to be taken according to their “discretion”.

Secrecy. Abortion and the BMA 1914 - 1915

Horace Avory and the Lord Chief Justice on the duty to inform (1915)

The same Horace Avory, now a judge, heard a case at Birmingham Assizes that prompted him to speak out on the question of informing the authorities in cases of known criminal abortion, in December 1914. Avory had not acted on a whim, for there was pre-existing concern in the justice system. In 1913 the Local Government Board approached the RCP about the reluctance of doctors to ascertain the incriminating facts in such cases when they presented to hospitals. Their reluctance, thought to be due to Lord Brampton’s statement, was felt by the Public Prosecutor (DPP) to be an impediment to the course of justice.

The case concerned a woman who had sought medical treatment following an abortion carried out by a lay woman, but had died very suddenly from septicaemia and massive haemorrhage. One of the three doctors involved in the case had ascertained the abortionist’s identity, but the “statement made by the deceased woman to a medical man [was] not evidence in a court of law”. Avory reluctantly decided that a case for murder could not be brought against the abortionist and took the opportunity to comment on the issues involved. He appreciated that patients who were obviously

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24 ibid., p. 114
25 ibid.
27 Saundby, memorandum CEC, 8.1.1915, in D170.
going to die had less incentive to keep silent on the identity of the abortionist, and doctors less reticence about asking. However, he said,

in circumstances like those in the present case I cannot doubt that it is the duty of the medical man to communicate with the police or with the authorities in order that [a statement be made to a JP] ... No one would wish to see disturbed the confidential relation which exists, and which must exist, between the medical man and his patient in order that the medical man may properly discharge his duty towards his patients; but there are cases ... where the desire to preserve that confidence must be subordinated to the duty which is cast on every good citizen to assist in the investigation of a serious crime such as [illegal abortion]. ... I have been moved to make these comments because it has been brought to my notice that an opinion, to which I was a party some 20 years ago, when I was at the Bar, has been either misunderstood or misrepresented in a text-book of medical ethics [Saundby’s] ... it may be the moral duty of the medical man, even in cases where the patient is not dying ... to communicate with the authorities. ... However ... I cannot doubt that is such a case as this present ... it was his duty, and that one of those gentlemen ought to have done it.^^

In fact the profession and Avory only really differed in their judgement as to how seriously ill a patient should be before considerations of secrecy were overridden by those of criminal justice. And neither Saundby nor Avory had represented the 1896 Opinion accurately; it had been vague, and both had adapted it to suit their own arguments. Yet the matter quickly became polarised. The *Lancet* reported Avory’s comments with the terse rider, “we doubt if there will be any general agreement in the medical profession with [his] views”. Before even the *Lancet* had published the report of the case, the Director of Public Prosecutions (DPP), Sir Charles Matthews, wrote to the BMA forwarding Avory’s comments, and stating that “it will be a satisfaction to learn that the inaccuracy in Dr. Saundby’s book will be corrected” and Avory’s views circulated to doctors.^^

**The Association’s response**

William Hempson replied that Avory’s views conflicted with Lord Brampton’s. The question merited “consideration” by “those within the profession from whom authoritative guidance is [sought]”, and he would refer the matter to the CEC.^^ Matthews replied that he would welcome this consideration, but that he wanted to “avoid a Press controversy”.^^ Hempson wrote back saying controversy was inevitable, but he suggested a meeting between the two of them, which took place a few days later. At this meeting, Matthews stated that the duty of doctors to the State was “higher” than their duty to their patients. Hempson asked Matthews if practitioners who did inform would be

29 ibid.
31 letter, Hempson, to Matthews, 15.12.1914, in ibid.
protected from civil actions against them. Matthews declined to commit himself on this, but told Hempson "in a measure of confidentiality" [sic] that Avory had the backing of the Lord Chief Justice.\(^{33}\)

Saundby sent the CEC a draft rebuttal of Avory’s comments, noting that the opinion of 1896 "d[id] not carry us very far”. He thought that

to give information involving prosecutions in all cases of criminal abortion would create scandals affecting not only the accused persons but the patients and their families. It is his desire to avoid this that justifies the medical practitioner in his own conscience in taking no steps, and he believes that public opinion not only supports him in this attitude but would be shocked and outraged were he to do otherwise; if any change is to be brought about it must be by fresh legislation that is sanctioned by public opinion.\(^{34}\)

The CEC prepared a resolution for the Council,

1. That the Council is of the opinion
   a) that a medical practitioner should not under any circumstances disclose voluntarily, without the patient’s consent, information which he has obtained from that patient in the exercise of his professional duties, and
   b) that the State has no authority to claim that an obligation rests on a medical practitioner to disclose voluntarily information which he has obtained in the exercise of his professional duties, inasmuch as it affords him no protection from any consequences which may result from his so doing.
2. That this resolution be forwarded to the appropriate Department of State and the whole question be ventilated in the *BMJ*.\(^{35}\)

Council further strengthened this resolution by removing the phrase italicised above, and did indeed send it to the DPP.\(^{36}\) This action resulted in a meeting being arranged between the BMA and the Lord Chief Justice on the 3rd of May 1915.\(^{37}\)

At the meeting the Lord Chief Justice intimated that what was sought was information on abortionists, rather than on “the poor unfortunate creature on whom the attempt has been made”.\(^{38}\)

He had also stated at the outset of the meeting that “no observation made by him during the discussion should be treated as a judicial pronouncement of the law”. Following the meeting,

\(^{33}\) memorandum, CEC, 8.1.1915, in ibid.
\(^{34}\) Saundby, memorandum for CEC, 8.1.1915, in ibid.
\(^{35}\) CEC, 8.1.1915.
\(^{36}\) Council, 17.1.1915.
\(^{37}\) CEC, 26.3.1915
\(^{38}\) letter, Hempson, to Cox, 4.5.1915, in CMAC SA BMA D170.
Hempson prepared a set of “limited circumstances under which it is desired that medical men
should give information to the authorities”. These were, that the doctor needed to be “of the
opinion” firstly that an artificial abortion had been carried out; that it was carried out by another
party; and thirdly that “the medical man was convinced in his own mind that his patient was in
extremis and that there was no hope of her ultimate recovery”. The wording of these conditions had
to be agreed with the LCJ’s office. However, the CEC proposed that they publish their own
resolutions along with the guidelines agreed with the LCJ. Council further strengthened this stance
by adding a rider to the resolutions stating, “having received the report of the Conference with the
Lord Chief Justice, the opinion of the Council is unaltered, and it adheres to the following
resolutions”. This defiant statement was published in the BMJ. Council also wanted to involve
the Royal Colleges in a conference on medical secrecy, and wrote to the RCP(L) and the RCS(E),
but their invitation was declined by both.

The RCP had themselves been approached by the DPP, and had passed their own set of
resolutions on the question of medical secrecy and abortion in July 1915. Their response was
similarly robust, but much more detailed. They gave very clear instructions to practitioners as to
what they should do, rather than stating the point of principle and delegating the decision entirely to
the doctor. In basic principle however the two responses were in agreement. But the College for
instance also gave a list of the different kinds of declarations, what was required to make them
valid, the procedure for obtaining them, and their differing legal standing.

The wrong kind of privilege: The Royal Commission on VD (1915)

At almost the same time the Royal Commission on VD consulted the BMA about secrecy in
connection with their proposed network of clinics. Article II(2) of the Public Health (Venereal
Diseases) Regulations 1916 stated that all information obtained during treatment under these
statutory regulations was to be regarded as confidential. This was not a legal endorsement of
absolute secrecy, but it was felt that people would be more likely to attend if the clinics were
confidential. On the other hand, the Royal Commission also wanted to limit the spread of VD by
allowing doctors to warn partners and potential partners of patients. Recommendation 25 of their

39 CEC 28.5.1915.
40 Council, 30.6.1915.
43 letter from RCP, CEC, 8.10.1915.
Report was to ask for statutory changes to make communications intended to delay or prevent marriage to be “privileged”. The situation envisaged here was discussed so often in connection with professional secrecy that it is worth denoting it ‘the case of the syphilitic fiancé’ for brevity’s sake. The doctor knows that his patient has VD and also that marriage is proposed. The moral dilemma was a simple one; should he tell the bride to be or her father in order to prevent the “innocent” third party from infection? Saundby advised “objecting to the marriage”, but did not say whether to breach confidentiality, Aitchison Robertson thought the father-in-law should be informed, and Woods, asking where such objection would end, counselled silence. As we shall see the question also divided the ARM.

The CEC were “very strongly of opinion” that “a medical practitioner was not at liberty, except with the consent of the patient, to make such communication ... and that no amendment of the law is called for unless and until the duty of making such communications is imposed on medical practitioners as a statutory obligation”. They wanted the ARM to resolve that “no amendment of the law to provide that a communication such as [had been outlined] shall be privileged is called for”. In other words the CEC did not want to see doctors enabled to share medical secrets with second parties by law, but were more comfortable with the possibility of a statutory responsibility, such as that incumbent on doctors to notify diseases.

The motion was debated along with the rest of the proposed VD regulations. Considerable disagreement existed between those who felt the regulations should compel disclosure (Edinburgh and Leith Division) and those were affronted by any suggestion that individual judgement was insufficient (Hawthorne). Bishop Harman felt that they should move that the statutory changes “would not be of real effect”. Only Jenner Verrall separated the questions of whether or not ‘to tell’ from the question of privilege. In the confusion the motion was lost.

The question of privilege was confusing. On this occasion they ARM had declined “privilege”, but within seven years the same meeting was to clamour for “privilege” in Courts of Law for medical confidences. The term privilege not only carried a spurious ring of prestige, but had two meanings
with opposite effects in connection with medical confidences. The kind of “privilege” envisaged by the Royal Commission, and relied on by William Playfair, was the kind that allows revelation without fear of action for slander. The kind sought later by the Association was that enjoyed by lawyers, and would have allowed doctors not to reveal information about their clients in court without being in contempt. The Divisional representative who were to agitate for the second kind of privilege voted down a motion that aimed to prevent the first kind implicating them in systematic informing on their patients. The transcripts of the meeting indicate that they were more confused over the morality of revelation than the technicalities of privilege.

**Cases considered 1916 - 1920**

The CEC was often asked to advise on secrecy in the meantime, and their advice was usually to stick closely to the principle of secrecy, and to resist anything other than statutory requirements to give information. For example, in a divorce case hinging on drunkenness, a doctor was advised to say nothing about the husband’s three episodes of *delerium tremens* unless or until he was subpoenaed by the Court.\(^{52}\) After a baby was found abandoned in Brighton, local practitioners were asked, in a typical request, by the police for information on any women they had seen suffering the after effects of labour. The Brighton Division was urged to maintain “the highest traditions of the profession in regard to professional secrecy”.\(^{53}\) In 1918 the LGB issued instructions to all Medical Officers of Health that required them to inquire into the circumstances of all cases of still birth or miscarriage where a positive Wassermann Reaction\(^{54}\) had been found. The CEC asked for a warning to be placed in the *Journal* about this, stating that “it would be wrong legally and ethically to furnish the information which the LGB has suggested [MOHs] should endeavour to obtain.”\(^{55}\)

**The Judicial challenge to Professional Secrecy 1920 - 21**

**Justice McCardie prompts a resolution**

The non-statutory confidentiality of the VD clinic system was challenged in 1920 by a decision made by Justice McCardie in a hearing for divorce on the grounds of adultery and cruelty, the proof being the passing of syphilis from husband to wife. McCardie ordered a Medical Officer from the Westminster Hospital’s VD Department, set up under the 1916 Regulations, to give evidence of the

\(^{52}\) CEC, 6.10.1916.

\(^{53}\) ibid.

\(^{54}\) a serological test for syphilis.

\(^{55}\) Council, 24.4.1918.
husband’s condition. He ruled that whilst secrecy was desirable he was justified in overriding it because “in a Court of Justice there were even higher considerations”.

Council considered this ruling, along with material prepared by the CEC and Hempson, who pointed out the confusion of legal, medical and lay opinion when it came to ‘the case of the syphilitic fiancé’ (or husband). He said,

It appears to be held by some medical men and ... certainly [by] some members of the lay public, that the ethical principle that a medical practitioner should not disclose without the patient’s consent ... does not apply to the same extent where the patient is ... suffering from VD. It has been suggested ... that the [partner] has a right to be informed ...

The CEC on the other hand advised “strongly against any relaxation of the immemorial tradition of the profession that the confidence of patient must be regarded as sacred”. They argued that such “relaxation” would deter patients seeking consultations with doctors that were in both the individual and the public interest. They invited the Council to offer the ARM a resolution that

having carefully considered the question of professional secrecy more particularly with regard to VD [the Association] reiterates its opinion that a medical practitioner should not under any circumstances voluntarily disclose, without the consent of the patient, information which he has obtained from the patient in the exercise of his professional duties.

This proposal bounced back to the CEC, but was passed when it was presented unaltered to Council: a sequence of events that could be seen to reflect confusion on the issue. Not only was there a real moral dilemma at the heart of the question, there was also a confusion between two situations, the private and the public disclosure, which whilst it was never openly acknowledged, must have added to the muddle the Association was evidently in. In private between individuals, subtle tip-off, fudge and innuendo could be employed and have the desired effect, whereas in Court full disclosure was demanded in a setting that at once made the information public. Thus when Hempson discussed the resolution at the ARM, his rhetorical question to the meeting as to whether they would inform in ‘the case of the syphilitic fiancé’ was met with an uproar of “yes” and “no”.

The meeting also discussed the lack of medical privilege, and Guy Dain, supported by E B Turner took the stance that the issue was one of precedent, and that the current position had only come

57 Agenda, Council, 18.2.1920.
58 ibid.
59 ibid.
about for want of sufficient "organisation". The meeting passed the CEC’s resolution, but also asked the CEC to consider to what extent the Association could support those who defied the Courts. They also resolved "almost unanimously" to press for the notification of VD, despite misgivings about information leaking out "in the smaller towns where people were all known to one another".

Whilst the CEC’s initial deliberations on the question of supporting defiance of judges were rapidly overtaken by events, it is worth noting their response to the ARM’s request, which was based on a memorandum by Anderson. This pointed out that not only was it sometimes clearly the duty of doctors to breach professional secrecy, the law allowed judges to override it. He argued that the Association could not be seen to support breaking the law, or contempt of court, but rather that doctors should do all they could to obtain the necessary consent. Any system of support would necessitate the formulation of guiding principles, but "even if all the members of the Association were cognisant of [them], it is extremely doubtful whether the Association could support its members." The Council, perhaps with the Coventry case still in mind, supported this stance.

Two cases and a resolution too far

It is hard to know if the ARM were unlikely to uphold the CEC’s stance on supporting ‘conscientious objectors’, but their opposition became almost certain after two more judicial interventions early in 1921. These cases are best described in full, but these accounts are drawn from several sources.

The first, the 'Chester case', again involved a VD clinic. A woman attended the clinic with her infant who was suffering from ophthalmia neonatorum, a gonorrhoeal eye infection. This was cited as proof of her adultery in the subsequent divorce proceedings. The doctor who had attended her at the clinic was called as a witness, but protested that the information requested was confidential. The judge was reported to reply "that the law gave him no special exemption, and did it with an abruptness and brusquerie which give the impression that the judge had for the moment forgotten the existence of other learned professions besides his own." The second the 'Ilford case' involved

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62 The Times, 2.7.1920, 9a.
63 Memorandum, CEC s/c, 9.11.1920.
64 Council, 16.2.1921.
65 CEC, 17.6.1921.
an estranged married couple, living apart. The wife had become pregnant and the father denied paternity. The child was still-born, and the birth was notified fully by Dr Burton, the MOH for Ilford, giving details of the true paternity. This information, required by statute rather than by simple professional relations, was demanded by the judge to prove or disprove adultery as grounds for divorce. The judge overruled the protests of both Dr Burton and the Ilford Urban District Council.67

The CEC meeting in June considered both cases, but “after discussion resolved to move on to the next business”.68 However the matter was brought up directly at Council the next week. Here it was resolved to communicate with the Ministry of Health about the ‘Chester case’, pointing out that this “violated” the “undertaking” of the LGB that such clinics would be confidential, and urging “that such legislative steps should be taken as would render such an occurrence impossible in the future”. The Council had considered asking for a privilege equivalent to lawyers’ but had dropped this from their resolution.69

Thus whilst the CEC had had no time to change the resolutions they proposed for the ARM, these cases were fresh in the minds of the Representatives. The CEC’s resolution effectively stated that there were exceptions to the rule of professional secrecy, that these were the rulings of the courts and existing statutory requirements, and that anyone defying these orders would have to do so “entirely on his own responsibility”. A second clause went on to state that if any extension of these exceptions to the rule of secrecy was proposed, the Association should resist by “all lawful means”, and “accord support ... to any individual practitioner ... assailed through such new encroachments.”70 Langdon-Down did his best to explain that any other stance would be simply illegal, and that the Association had taken matters up with the appropriate authorities, but stronger passions prevailed. To great applause E B Turner said this was “a matter that would almost surmount anything else that was done at this meeting. (Applause)”,71 and Dain urged the Council to take “a much stronger attitude”. He felt that the “whole basis of confidence between their patients and themselves was going to be destroyed” by these judicial interventions. “It was certain the public had not the slightest doubt about the matter. (Hear, hear.) The ordinary layman was quite

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68 CEC, 17.6.1921.
69 Council, 22.6.1921.
70 Council, 16.2.1921.
positive that his doctor should never under any circumstances tell anybody. (Applause).”

Few, aside from Brackenbury, Bolam and Hempson dared support Langdon-Down, in a long debate in which Hippocrates and public opinion figured large. The meeting decided to support resolution tabled by Dain, with the addition of the phrase in italics,

that the Association use all its power to support a member of the BMA who refuses to divulge, without the patient’s consent, information obtained in the exercise of his professional duties, except where it is already provided by Act of Parliament that he must do so.\(^7\)

Hempson raised the objection that since this resolution had not been published two months in advance in the *BMJ* it could not be the policy of the Association. This blocking tactic was easily brushed aside by the resolution proposed by E R Fothergill and James Macdonald,\(^74\) that the resolution be resubmitted next year with a view to its becoming Association policy. The CEC had a year in which to try to change things.

**Tradition and Solidarity v. Legality and Reason**

The ARM of 1921 essentially drew up battle lines between those who regarded the law and the judiciary as reasonable targets for organised resistance by the medical profession, and those who sought to defend the principle of secrecy but with due regard for the law, and the other instances in which revelation of information was the more ethical and reasonable path. The dispute within the BMA was between the CEC, which supported Langdon-Down’s views by and large, and the Council, dominated by men like Dawson, Turner, Fothergill and Dain. Outside the Association Lord Dawson and the Lord Chancellor, Lord Birkenhead, contributed bad-tempered formulations of the medical and legal perspectives in print. However the chronology of events does not serve to clarify the basic positions in this debate. I shall set out the wrangling within the BMA first. I shall then turn to the statements made by Dawson, the counter-blast to the profession delivered by Smith, and comments from F G Crookshank, a doctor who sympathised with the legal perspective.\(^75\)

\(^{72}\) *ibid.*

\(^{73}\) Minute 45, ARM 1921.

\(^{74}\) “For many years he must have spent about a third of his waking hours in the work of the BMA, mostly in London. His general practice in Taunton naturally suffered in spite of the co-operation of his colleagues. ... on what proved to be his death bed, he said ‘A bachelor must have some substitute for married life - some hobby, and be prepared to pay for it. The BMA has been mine.’” Cox, *Among the doctors*, 1950, p. 84.

\(^{75}\) Dr Fancis Graham Crookshank, (1863? - 1933) was evidently a most fascinating man, and this note simply outlines the main points of his career. Crookshank trained at UCH, and following work as an asylum medical officer, medical officer of health and general practice also developed a career in psychological and neurological medicine, becoming an FRCP in 1920. He was on the visiting staff of Belgrave Hospital for children, Hampstead General Hospital, the Mildmay Hospital, the French Hospital, and was Physician to the Prince of Wales General Hospital and to St. Mark’s Hospital. Crookshank
The CEC backs Langdon-Down

Langdon-Down submitted a “personal” memorandum on this subject to the CEC, intending it to be the starting point of a discussion. In it he set out his view that the resolutions of 1921 taken with those of 1920 formed a contradictory policy nightmare. The earlier resolution, which had not been rescinded, allowed doctors to refuse to obey, whilst indicating they ought to, whilst the newer resolution encouraged refusal, and promised support, but did not stipulate that they should so refuse. The exception about Acts of Parliament in the new resolution implied not only that secrecy was not absolute, but that the current statutory limitations were not to be changed. On the other hand it was evident the ARM thought secrecy should be inviolate, and that the recent judicial interventions hurt “the deepest feelings of decent honourable men.”

Yet, he continued, the principle could never be absolute; notification had been opposed initially but was now accepted, and indeed many in the profession were calling for the notification of VD. What was more, “the same medical man who recounts his refusal to disclose information at the bidding of a judge ... equally vigorously asserts” that he would inform the bride’s father in “the case of the syphilitic fiancé”. In other situations too, such as discovering a spy, or dangerous criminal, or the need to prevent “an epileptic driving a train” or “a lunatic being at large”, a doctor would see it as his duty to override secrecy.

He suggested the judge was the perhaps the best person to decide when secrecy should or should not be breached. There was certainly no evidence that the present ‘encroachments’ were preventing people coming forward for treatment. He described a suggestion by Robert Bolam, that legislation should protect medical confidentiality but leave a loophole for the individual doctor to inform if he saw fit, as combining “the lesser degree of public advantage and the most invidious possible position for the practitioner”. Langdon-Down’s analysis went on to bring in public opinion, saying that public awareness of the limitations of secrecy was the key. If these were widely understood “then we shall not be open to the complaint that we have acted dishonourably. There are exceptions

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was noted for his holistic or neo-Hippocratic approach to disease, was intimately concerned in the founding of the Medical Society of Individual Psychology, and was on the staff of Institute of Medical Psychology “when it was known as the Tavistock Square Clinic”. He was also a noted historian of medicine and francophile.

*Br. med. J.*, 1933, ii: 848, and *Medical Directory*.

76 Memorandum, CEC s/c, 10/11/1921.

77 ibid.

78 ibid.

268
[to absolute confidentiality] and for our own self-respect it is better to warn the public clearly of this." The policy the Meeting had decided on was designed to create a stir, so that defiant doctors "will be hailed as martyrs by a grateful public and that a new custom will in due course be established according full privilege to a doctor." Instead, he suggested, judges were the appropriate people to decide these issues in court, and he proposed that public recognition of the current limitations to confidentiality as the only practicable way of satisfying the demands of honour and the public interest.

The sub-committee agreed with him, and the CEC adopted his memorandum as their report. They drafted a long series of careful resolutions, firstly that,

from the widest view of the public interest there must be exceptions to the general rule of professional secrecy, and that to safeguard the honour of the profession this fact should be openly recognised and made clear to the public, and that the nature of the exceptions should as far as possible be defined.

The resolution went on to state the rule that information gained in clinical encounters should not be revealed without consent, but then outlined three exceptions. These were; when obliged by an Act of Parliament or Order in [Privy] Council; when ordered by a Court of Law (although a later rider to this added, "it is conceivable that in some instances the medical witness may find himself unable to accept the direction of the Court"); and lastly where a practitioner's duty as a citizen over-rides his professional obligation. Of this three examples were given; to prevent the commission of a crime; to prevent grave danger to other parties when all other measures had failed; and in the interest of the patient.

A second resolution stated that since there were exceptions, it could not be the policy of the Association "to promise undiscriminating and unquestioning support to any member of the Association who may disobey the order of a Court" and thus the Association could not to confirm the Minute 45 of the ARM of 1921. However, a resolution stated it should "be the policy of the Association to sustain the principle of professional secrecy on the highest level consistent ... with ... the public interest", and to this end it would, if the Council or CEC thought it appropriate, support any doctor who was treated "harshly or unjustly ... in the exercise of his professional duties to the highest public interest". The committee also planned a fall-back position, in which they would propose that the word "already" be deleted from Dain's motion, allowing new legislation to influence secrecy. With the addition of some material by F G Crookshank on the exceptions to the

79 CEC s/c, 10/11/1921.
rule of secrecy, and other small changes, this document and set of resolutions was submitted to Council in December 1921.  

The CEC challenged by Council

The Council disliked this memorandum to the extent that they first postponed discussing it to a special meeting, at which they then referred it back, not to the CEC itself, but to a “special meeting” which would also be attended by Lord Dawson, Guy Dain, E R Fothergill, James Macdonald, E B Turner, and Jenner Verrall. In other words, the CEC were sat down with leading members of the BMA Council, who disagreed with their stance, and made to reconsider their position. When Langdon-Down took the chair at this strange meeting, he first asked what exactly it was. Bolam suggested it was a “re-inforced CEC”, but it was agreed to consider it an ad-hoc body, chaired by Langdon-Down. The meeting considered material prepared by Fothergill, Dain, and W A Brend, a barrister and doctor.  

Fothergill’s memorandum described Langdon-Down’s as “vague” and “inconsistent”, and characterised it as a defence of a policy the ARM had rejected, out of dislike for the policy they had adopted. It was not a matter of what Langdon-Down had at the ARM termed “professional pride, dignity and jealousy”, but “a matter of conscience” which Fothergill defined, quoting Tredgold, as

> the quality of mind which enables man to feel that he has obligations to society which makes him sensible of the ideals of honour and honesty; of compassion and chivalry; of patriotism and altruism; and which not only restrains the individual from wrong doing, but impels him to do right

Fothergill placed the doctor-patient relationship above “the disposal of litigation”, and outlined a scheme, rather reminiscent in it tone and scale to the contract practice boycott scheme. Firstly the doctor should formulate his refusal in the terms of the ARM resolution. As a condition of support, doctors should contribute a percentage of their income to a central fund, on which they could then draw if they were prosecuted. The local Branch or Division would carry on the doctor’s practice for him whilst he was in jail, and the Council, through the MPC could “educate and focus ... opinion in favour of the member”.  

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80 CEC s/c 19/12/1921.  
81 Council, 18.2.1922.  
82 Council, 18.2.1922.  
83 CEC(Professional Secrecy Committee) 31.3.1922.  
84 Fothergill, memorandum.
Dain’s memorandum was less spittle-flecked, better informed and more moderate, but nonetheless determined. For him this was “a moral issue, and must remain a matter for the individual conscience in every case”. Dain recognised a distinction between secrecy and privilege, and sensibly pointed out that doctors should warn patients when they felt confidences were about to be made which could not be protected by professional secrecy. He also pointed out the differences between civil cases, such as divorce, and criminal charges for murder etc, arguing that in the former, the doctor’s evidence was exploited as a convenient “short cut”. As far as he was concerned the 1921 resolution did not commit the Association “to spend its last penny” but would most probably simply entail local support in taking care of the doctor’s practice whilst he served his sentence for Contempt of Court.

Dawson then proposed that

that the proper preservation of professional secrecy necessitates a measure of privilege being recognised for medical witnesses in Courts of Law above and beyond what is accorded to the ordinary witness

A “considerable discussion” followed in which opposing notions of the legal definition of privilege were proposed. The compromise statement, carried by 10 to 4, was

that the measure of privilege to be aimed at is that no registered medical practitioner shall be compelled without his patient’s consent to disclose any information which he may have acquired from his patient while attending them in a professional capacity.

A unanimous addition to this read

Meanwhile that it be the policy of the Association to support in every way possible way any member of the BMA who, in the opinion of Council, or the CEC acting on behalf of the Council, after due consideration of the circumstances, is deemed to have been justified in refusing to disclose any information he may have obtained in the exercise of his professional duties.

Thus once again, a legal risk for the Association was to be taken on the strength of the opinion of the CEC. The meeting also resolved “That the Hippocratic Oath be published in the Journal”.

William Hempson wrote to Cox four days later expressing his concern that the Association’s stance could cause real problems with malpraxis cases, “inspired and run by unscrupulous and speculative solicitors” in which doctors’ evidence for the defence routinely broke professional secrecy.
Furthermore, "it does not fall to the lot of every one to possess that 'quality of mind' [described in] the quotation from Tredgold". Cox’s replied,

I am bound to say I have never felt less comfortable over anything than I do over this. My report is based a good deal on points put forward by Dr Dain and I have tried to make it ... as convincing to myself and others as I could. But frankly I am not convinced ... There are far too many exceptions to be made in this business to put up any rule, and it all boils down finally (unless the Representative Meeting changes its opinion) to the fact that the BMA is to give its support to any man whose conscience inspires him to tell a judge in a Court that he is not prepared to divulge the confidences of his patient. There is something rather fine about that and it is an attitude which I think a great many of the public would respect, but it is quite hopeless to try to build up a series of rules and regulations and to try to make it look logical and watertight. The attitude rests on sentiment and tradition and it is no good trying to invest it with logical consistency. The instances you adduce in your memorandum are to my mind impossible for us to answer.85

The Secrecy Committee met again a few days later and considered the document Cox had put together. It was inconsistent, obviously pasted together from Dain’s memo, Brend’s list of conditions on which the Association could support a doctor, and an “appendix” by Langdon-Down which argued against the rest of the Report for co-operation with judges. Aside from the resolutions, the plan was for the Association’s support to take the form of legal advice, local support, influencing public opinion and a “Medical Secrecy Defence Fund”.86 (Hempson later stated this plan was outside “the legal competence of the Association”).87 In Council Langdon-Down declined to present the report and resolutions, leaving this to Dain. The report and resolutions were adopted by a bare majority of 16 votes to 14.88 Dawson and the others had achieved a complete reversal of policy within the space of a month.

The 1922 ARM

At the ARM two motions were passed, the first made it “the policy of the Association to support in every way possible any member ... who in the opinion of Council or of the CEC ... is deemed to have been justified in refusing to disclose any information ... obtained in the exercise of his professional duties.” The second stated that “the proper preservation of professional secrecy necessitates a measure of special consideration being recognised for medical witnesses in Courts of Law above and beyond what is accorded to the ordinary witness.” Fothergill proposed an

85 letter, Cox, to Hempson, 6.4.1922 in D170.
86 CEC (Secrecy), 11.4.1922
87 hand-written letter, Hempson, to Cox 11.4.1922 in CMAC SA BMA D170.
88 Council, 26.4.1922
amendment, which added to the forgoing a statement that it was “an essential principle of medical conduct” that secrets should not be “divulged without the consent of the patient concerned”.

Langdon-Down and Lyndon, in a last ditch attempt then proposed that the meeting also add the words “save to prevent grave injury or injustice to the state, the patient, or other members of the community” but were voted down. The motion as amended by Fothergill was passed.\(^9\)

Thus the Association had publicly resolved that medical men could refuse to testify in cases where they felt unable to, and that the Association would support deserving cases of ‘conscientious objection’ in “every way possible”. The thinking behind this was that in making a stand the profession could establish a new precedent to override the Duchess of Kingston judgement of 1776. Before examining the legal response to this position, I shall describe the views of Dawson on the topic.

**Lord Dawson at the Medico-legal Society**

There were parts of this speech which were well reasoned and well researched, and many of the lawyers in his audience were sympathetic to these points, but the newly ennobled Dawson revealed himself to be petulantly jealous and irritated by the legal profession. Thus, despite addressing the “friendly conclave” of the MLS, in order to suggest “round table” discussion on the question, he also used the occasion to attack the Law. His speech was not printed in the society’s *Transactions*, indeed, it would have been completely out of place there, but it did appear in *Lancet*,\(^9\) along with a summary of the discussion, which carried on into a second meeting a week after his speech.\(^9\)

His key proposal was that New Zealand’s Evidence Act of 1908 could provide a compromise solution to the problems facing doctors. This stated that unless matters of criminal activity, fraud, or insanity were in question, a patient’s consent was required before a doctor could reveal medically obtained information, and thus set up a distinction between civil and criminal action that Dawson thought quite appropriate.

However, he moved from this sober proposal to a swingeing attack, saying that “the privilege of the lawyer is, in practice, all but complete”, and characterising the Law as “the spoilt child of the professions”. Lawyers argued that medical evidence was required to ensure justice, when more

\(^9\) ARM, 1922.


\(^9\) *Lancet*, 1922, i: 641 - 643
often it was a matter of judicial convenience to use the evidential short-cut of medical testimony. If the “spirit of the English Law” allowed lawyer-client communication absolute privilege “what of the spirit of English Medicine? Law deals with justice: medicine with life and health. Can it be contended that one is more important than the other?” he asked.

How could GPs, whose “art” relied entirely on the evidence of the patient’s own history, and thus on their frankness, manage if an already reluctant population became still more scared of consulting their doctors? Dawson also spoke of two “hypothetical” cases, though it is tempting to think he had specific patients in mind. One was a happily married woman who had earlier had an illegitimate child. The other was that of a man “unburdening to his doctor a load of care which has been disturbing his mind and prejudicing his recovery ... concern[ing] some wrongdoing in earlier life. ... Is the law to have the power to take advantage of [a] patient’s illness and compel the doctor to disclosure? ... If so all honour is at an end.”

In the discussion that followed it was clear both lawyers and doctors present felt this was an inter-professional dispute, even if they spoke to a moderate view. Thus Lord Riddell (who published on secrecy later) said “Doctors were always anxious to improve their status; but he had not heard whether the patients desired that doctors should have this privilege in civil proceedings.” Lord Russell who thought some exception should be made for VD, nevertheless pointed out that “even in civil law it would be a dangerous ... to give to the medical man unqualified privilege ... Doctors were a numerous class and not all of them had the high ideals which guided the members of this Society.” Lenthal Cheatle argued that the failure of ophthalmia neonatorum notification by doctors in many cases showed how individual doctors could not be relied on to act in the interests of public health. One doctor spoke passionately in favour of Dawson’s view, and looked forward to “more doctors in Parliament”. Even the President, in a summing up that recast Parliament as composed of “patients” rather than “lawyers”, asked if doctors really wanted to be put into a position whereby their fee bought their silence, at the price of their honour and duty as citizens. Dawson, in his answer, moved not one inch from his initial position, and the next week voted in the BMA Council to alter the CEC’s report on secrecy.

92 The discussion was also reported in The Times, 22.3.1922, 9f., and 29.3.1922, 10c.
93 Lancet, 1922, i: 642.
94 ibid.
95 ibid.
96 ibid., 643.
Crookshank's reply

Crookshank, who was Vice-President of the MLS and also a member of the CEC, resigned from both bodies over these events. In a speech to a local BMA Branch that summer, that appears not to have been reproduced in *Lancet* or the *BMJ*, he characterised the MLS meeting as a disaster, saying, "a very bad impression was made on the distinguished lawyers then present when one medical man after another propounded various hypothetical and fantastic cases ... revealing an extraordinary ignorance of the practice of our Courts ... and the rules of evidence." The only cases of real hardship, he argued, were the two cases that had triggered the furore in the first place. The Hippocratic Oath contained no absolute injunction against anything other than gossiping, and nobody swore it in any case. The 'case of the syphilitic fiancé' was, he said, "the favourite instance of the medical casuist ... so often spoken of as likely to occur, yet which hardly ever does." As for evidence or knowledge of crimes, "the doctor who gives an absolutely binding pledge of secrecy without first stipulating that [this could not cover] collision with the law, is a fool and a negligent fool, for whom there is no excuse."

He went on to imply that doctors were too inquisitive, and that "careless and imprudent practitioners" were "regarded as good sports by habitual offenders". His criticism and disdain went further. "I can quite conceive", he said,

that some gentlemen whose clientele is drawn from certain classes of society may feel the shoe to pinch them more frequently than it does others, I must frankly confess that the proportion of my own patients who are either criminal or immoral and who fear exposure in Court, is almost negligible. I am partial, but I do not fear any grave consequences to the public health if a few abortionists and diseased adulterers find their walk in life becoming a little hard for them.

The duty to tell the truth in court was "more urgent that the shadowy obligations said to be imposed by the so-called Oath of Hippocrates". If a doctor found himself called on to breach a confidence he should appeal to the judge, who would most often suppress the question, or if it was important to the case, relieve the doctor of any legal or moral responsibility for what he would reveal.

we can only maintain our professional pride, prejudice and privileges if we seek to do so in subordination to the rights and interests: (i) of the public of which we are a constituent, and (ii) of abstract justice. I would never seek to maintain the Public Health at the expense of public justice. Public Health without public justice is mere brutality.

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97 South Midland Branch, 29.6.1922.

98 Crookshank, F G, *Professional Secrecy*, London, Balliere Tindall and Cox, 1922. This appears to have been a privately published pamphlet, a copy is in CMAC SA BMA D169.
He, for one did not wish to see injustices done in order that “we may maintain, in a narrow consistency, the naked principle of professional secrecy”.

“Should the doctor tell?”

Since Lord Birkenhead (Frederick E Smith) was Lord Chancellor at the time, his critique, entitled “Should a doctor tell?”, published in a book of essays for general readership, is most significant. Birkenhead combined his high office with well-practised skill in writing entertainingly for the public. For Birkenhead, the question was not one of “professional partisanship” but “of the broadest concern”. He started his argument, by demolishing the legal grounds for absolute privilege in any profession including law. The lawyers’ privilege, he argued, only extended to cover communications that were made in preparation for a case and there was no privilege for priests in English law. In any case there was “scarcely any analogy” between this and the claims being made by doctors. He admitted, and affirmed, that “common sense and ordinary feelings of honour would prevent a doctor from gossiping”, but as for any absoluteness; doctors attitudes to ‘the case of the syphilitic fiancé’ demonstrated the difficulties in making such a claim. “The ultimate decision” in that kind of situation, he commented sharply “must be taken in accordance with the high ethical sense of a learned and honourable profession”. He did not indicate that he meant doctors here.

The arguments put forward for medical privilege were “discordant and loose” and left a long list of questions unanswered. Doctors’ woolly thinking was exposed in cases where they had knowledge of crime. A case had been recently recounted and “applauded .. apparently with complacency, at a professional assembly” in which a doctor had stopped a wife poisoning her husband by tactfully mentioning the possible diagnosis to her, but no more. For Birkenhead there could be “no more dangerous precedent. Consider the facts and the looseness of the reasoning ...

99 Frederick Edwin Smith, Lord Birkenhead (1872 - 1930) was the son of a Birkenhead barrister, educated at Wadham College Oxford, and taught law at Oriel College, before being called to the bar in 1899. A Unionist Tory he quickly gained a high reputation as a barrister, and a seat in parliament in 1906. Once in London both his political and legal careers flourished. He was made Attorney General and knighted in 1915, and elevated Lord Chancellor and made a Baronet in 1918 by his one-time opponent Lloyd George, serving until the fall of the coalition Government in 1922. In 1924 he became Secretary of State for India. Smith, a brilliant fiery speaker, was extravagant and flamboyant and “always spent what he was about to earn”. This took a toll on his health and finances, and he turned to writing popular books in his later career to make ends meet.

DNB

100 Smith, Frederick Edwin (Earl of Birkenhead), Points of View. Vol. 1, London, Hodder & Stoughton, 1922, p. 36

101 ibid., p. 39.

102 ibid., pp. 43 - 5
[the doctor] assumes his tongue is tied, [and] that he must impale himself on the horns of a dilemma”. All that had happened was that a proven crime had gone unpunished. The effective protection of criminals continued in other respects too, abortion was “rife” and “numerous” cases had to be dropped, and still more never saw the light of day, all due to the concealing actions of doctors.103

More damaging still, Birkenhead discussed another crime, not addressed elsewhere in this debate, charging doctors with effective complicity in child sexual abuse. He used this to devastating rhetorical effect, recounting the “amazing” refusal of a medical laboratory worker to disclose VD test results that would have proved that a child had been assaulted. He asked, “what kind of confidential relation has been set up between this elderly syphilitic violator of his own child and the laboratory staff to whom he is only known through a specimen ... of his ... blood?”104 He went on to outline the difficulty in securing prosecutions for child rape, especially if doctor would reveal nothing until they were in court.105 Thus the argument over the claim to a privilege of secrecy was not, he claimed, between two professions, but between “those who claimed [it] and the parents of the children the law sought to protect”. This was a low blow indeed. Doctors were not really shirking their duty, he argued in mitigation, they just didn’t understand their duty clearly enough.106 What was more “Judges ... are not biased against the medical profession nor men who would wantonly outrage the canons of decent feeling” and only asked for what was absolutely necessary.107 He went on to outline cases where doctors’ honour would dictate testifying rather than silence; including malpractice cases.

He did not stop there, observing that “doctors have no monopoly of medical practice”. “The Chemist,” he said, in what appears to have been a deliberate insult, “is a responsible professional man, admitted by examination into a class which has strong professional feeling and a high code of ethics”.108 He went on “are the Christian Scientist healer, the herbalist, the quack, the bone setter, the chemist to be covered by the same doctrine as the doctor?”109 Nor was the question limited to those practising medicine or healing, for modern life depended on a “web” of confidential relations. They could not all be absolute, he argued, without the complete collapse of legal redress in court.

103 ibid., pp. 53 - 6.
104 ibid., p. 56.
105 ibid., p. 60.
106 ibid., p. 63.
107 ibid., p. 64.
108 ibid., p. 69.
109 ibid., p. 71.

277
In conclusion, he said, "it is clear that no general statutory prohibition against disclosure by the doctor in the witness box is consistent with the administration of justice". The whole trend of the law in recent years had been to increase the number of those who could testify and the lawyer's privilege had grown "under the hand of the judiciary, who can be trusted to curb any abuse of it." The privilege asked for by doctors would be "retrograde ... and not justified by any argument brought forward". This was not only his opinion as Lord Chancellor, but one with which all judges and barristers agreed. And their opinion was, he said, "consonant with the whole scheme of our judicial history, and ... rests on the a solid basis of equity and common sense".

The Council backs down

Birkenhead's views certainly helped cool the BMA's ardour, and the Council had already been showing signs of realising the weakness of their heroic stance. In July Council postponed discussion of the plan to confer with the legal profession until October. The CEC reported in October that the whole matter needed detailed consideration and report before such a conference, implying that the documents and motions they had available were not presentable. They further suggested that a united approach from several professional bodies was required. Dawson attended a meeting of the sub-committee, which resolved to approach the RCP and the RCS to ascertain their views on the ARM motions. Given that the BMA had had no luck in interesting the Colleges in a united policy on secrecy only seven years before, and was to meet with the same non-co-operation again, it is just possible that the CEC was suggesting this as a delaying and spoiling tactic. The sub-committee also considered the text of Crookshank's address, but since they passed no resolution on it, we cannot know how his views were received by the Committee.

The CEC meanwhile announced itself prepared to advise the Council, or its Chair, in emergencies "as to whether or not the member in question [who had refused to testify] should be supported in every possible way". Following further discussions with Dawson about the proposed medico-legal conference, they reported that "in the view of the committee ... the task before the profession ... may well be one of extreme difficulty". Birkenhead's book was cited as "an indication of the

100 ibid., p. 74.
111 Council, 29/7/1922.
112 CEC, 26/9/1922, and Council, 25/10/1922.
113 CEC s/c, 14/11/1922.
114 CEC s/c, 6/12/1922.
115 CEC, 16/1/1923.
opposition [we] may be likely to encounter". Nothing could be achieved without the Colleges co-
operation on the issue. Council simply instructed the Committee to take no further action for six
months. Six months later Council agreed to the CEC’s proposal that no further action be taken, and
the Council’s Annual Report stated that “no useful purpose would be served by proceeding
further with it at present”. In fact the whole affair had swiftly reached its anti-climax. Only one
case, involving VD, was considered by the CEC as a possible “test case”, in November 1924.
There was apparently no prolonged discussion, and the member was advised that “it is not a test
case for the profession”. He should, the committee advised, outline his reasons for not wishing to
testify, but obey the judges orders. I have found no evidence that any other case was ever
considered for this purpose.

Attempts at legislation and further resolutions

Ernest Graham Little, the MP for London University and a consultant dermatologist, tabled two
private members Bills that would have made medical confidences privileged in law. Given
Birkenhead’s views it is not surprising that the first, a Medical Practitioners Communications
Privilege Bill, provoked by another of McCardie’s judgements, fell at the first reading in 1927.
Lord Riddell took the opportunity of this Bill to present a reworking of Birkenhead’s arguments at
the Medico-legal Society, which he published twice in the years that followed.

Further attempts were also made within the BMA. The ARM of 1929 resolved

that it be referred to the Council to consider whether the following definition of the Policy
of the BMA on Medical Privilege is desirable:- That communications between doctor and
patient unless they concern fraud, or crime or otherwise the public interest, ought to be
privileged from disclosure in Courts of Law

This time the CEC and Council used an interesting tactical manoeuvre to counteract this motion.
The sub-committee recommended to Council that “it was not desirable to add” the ARM 1929

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116 ibid.
117 Council, 14/2/1923.
118 CEC, 18/11/1924.
119 CEC, 18.11.1924.
120 The Times, 14.11.1927, 10d.
121 The Times, 23.11. 1927, 9a.
441 - 443, and later in, Riddell, George Allardyce Baron, (Lord Riddell), Medico-Legal Problems, London, H K Lewis, 1929.
minute “to the decisions made in 1922” in the BMA Handbook (not the Handbook for medical practitioners). The Council went along with this plan and their Annual Report, approved by the ARM of 1930, stated that the resolution had been dealt with in that way.

Graham Little tried one more time to pass an Act granting privilege, but his measure, the Medical Practitioner (Privilege) Bill was rejected at the second reading, when the Solicitor General used arguments familiar from Birkenhead and Crookshank.

**Doctors and their patients’ secrets 1922 - 39**

I shall outline a selection of cases presented to the CEC during the 1920s and 1930s. They demonstrate the conflicting moral and ethical pulls that doctors perceived. In practice, as the legal critics of what we could call the Fothergill-Dawson plan pointed out, doctors frequently felt honour-bound to break confidences.

**Honour and disclosure: ordinary doctors’ dilemmas**

For example, in April 1925, the committee considered an appeal for advice from a doctor who had seen a young heiress for a physical complaint. She was by her own admission, “mixed up with this psychoanalyst” who having been convicted of some offence was facing deportation. She had, the doctor learned, already given the psychoanalyst £1,600, and “she told me enough to let me see that she was not in her right mind, and that this man had evidently gained control of her”. Her aunt’s solicitor wanted the doctor to certify her unfit to look after her finances, and “a well known Mental Expert” had pronounced her a “borderland case”. The doctor was in two minds, “Am I professionally bound to secrecy? I know that she will give away all her money...”. Anderson, in consultation with Langdon-Down wrote to say there was no reason for him to break professional secrecy, but the member wrote again later saying, “I am strongly of the opinion that what is told in the consulting room is sacred. At the same time I do not want this man getting her money and I do not consider her in her right mind...”

Another case illustrates the confusions that many doctors made between the general demands of honour, decency and compassion, and the specific principle of secrecy. In this situation the member

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123 CEC s/c, 20.12.1925.
125 CEC, 16.4.1925.
who sought advice had been "greatest friends" with a couple who had fallen out. The husband had seen the doctor with an attack of acute gonorrhoea 2 years previously, and had been advised to abstain from sexual intercourse. He had not informed the wife of "the true cause of his disability" and had "behaved like a brute ... and she has gone in fear of her life". He had seen the wife recently, found her in a very "sorry state" and had, after protesting a little, told her of the gonorrhoea. When divorce proceedings were instituted the CEC advised him to do or say nothing unless ordered by the Court. A similar case came up seven years later. The committee once again advised the doctor not to give ANY information about the husband unless directed to do so in the witness box, and that he should only mention the gonorrhoea only if the solicitors asked for a FULL statement of his professional knowledge of her during the marriage.

The committee’s advice to members of whom information had been requested by MOHs was to preserve anonymity, but comply with the request. Thus a member asking about the "propriety" of answering a questionnaire about a patient who died of carcinoma, was told that it was permissible so long as patient was only referred to by a number. He was also advised that he should have been allowed to seek the patient’s family’s permission.

In another case a “Consulting Obstetrician to a few London Boroughs” had been asked by the MOH to furnish details of cases he had seen for the Maternity and Child Welfare Committee, and to comment on “the proper and efficient conduct of a case by a practitioner”. He was advised that since local authorities paid him he should co-operate by supplying the relevant details, preferably with the patients’ consent, and without revealing their identities. He should however “certainly” not criticise another practitioner whom he had met in consultation. It would be tempting to cite this case as an instance of “double standards” in that ethical advice suggested that doctors could testify in defence of doctors on malpractice charges, but not criticise them. The two contexts of court and local committee are different, so the argument cannot be made on this basis, although it would be consistent with the whole trend of advice given.

The deep reverence for the feelings of the patient in medical secrecy did not extend to children of course. The CEC had advised a school medical officer, who wanted to know if it was ethical for a school teacher or representatives of a committee engaged in welfare work to be present during the

126 CEC, 16.1.29.
127 CEC, 6.5.1936.
128 CEC, 22.12/936.
129 CEC s/c, 15/1/1935.
examination of a child, that they felt it unlikely to be "prejudicial". On another occasion they ruled that "no breach of secrecy was involved in producing school medical records if and when these are requested by a Court acting under the 1932 Children and Young Persons Act" and that parental consent for the use of the records was not required.

"Fothergill's last stand": The Brighton Trunk Murder

These cases pale in comparison with the decision by a whole Division to overrule Central BMA advice in the case of the "Trunk Murder" during the summer of 1934. This was a repellent crime; the torso of a woman, 5 months pregnant, had been deposited in a trunk at Brighton Station on Derby Day, June 6th and had been discovered on the 17th. Her legs had been found in a suitcase deposited at Kings Cross Station in London on the 7th and discovered on the 18th. The Chief Constable of Hove had written to all local medical practitioners laying out the details of the case, and asked for any information that doctors might have to help them identify the woman, saying that all information would be treated in the strictest confidence. The CEC always advised against co-operating with such enquiries, but here the list of doctors' names and addresses had been supplied by Dr Gemmell, Secretary of the Division. Fothergill, furious that

in this Trunk Murder sentiment will fog the issue”, complained that there was “a great deal of what I call Jesuitical casuistry prevalent. Otherwise "Sentiment". One [doctor] even said he knew of a possible patient and went to the parents or relatives to urge disclosure to the Police, and if they refused (fancy the possibility) he would feel justified in informing the Police himself.

Robert Forbes, as DMS, replied “the Chief constable’s request [for] names and addresses of patients ... ought to be declined ... on the grounds that [it would be] a gross breach of professional confidence...". He also wrote to Gemmell saying “there is a basic sacred principle involved which must not be whittled down.” He advised Gemmell to meet with Police and set out the profession’s objections. Meanwhile, Fothergill became convinced a wholesale outrage against professional secrecy was afoot. His secretary had shown him an article in the Daily Mail in which a Scotland Yard spokesman had announced their intention

130 CEC, 22.12.1936.
131 CEC, 23.1.1934.
132 Correspondence, CEC, 15.1.1935.
133 Letter Fothergill to Anderson 11.7.1934.
134 Letter Forbes to Fothergill, 12.7.1934.
135 Letter, Forbes to Gemmell, n.d. (given in file as an enclosure with Forbes to Fothergill 12.7.1934)
to comb every square mile of the country by enquiring of doctors, maternity homes, and clinics, whether they knew anything of any woman whose description fits in with that of the murdered woman, this in view of the fact that she was an expectant mother. ... Any information that may be obtained locally is to be carried to its uttermost limits.¹³⁶

This was all "to [Fothergill's] mind a most serious challenge to the Public Health", and he urged Anderson to consider the kind of concerted action for which he had such a penchant.¹³⁷

Forbes replied, "we feel it is unnecessary to go as far as you suggest" and continued, somewhat ambiguously, "it seems the profession is fully au fait with its position and is determined not to be dragooned into acting in a manner contrary to its best interests and ultimately to the best interests of the public at large."¹³⁸ A meeting of the Brighton Division failed to back Fothergill and felt quite at liberty to ignore Forbes' advice. Fothergill argued that the enquiry would turn up nothing but useless information, but would nevertheless affect "a large number of women and their relations and friends most of whom were already distressed at the position in which their relative or friend had found herself". In his view "innumerable" patients would be put off consulting if they publicly breached strict professional secrecy. The meeting voted 16 to 2 to disregard the advice of the Central Office.¹³⁹ The CEC considered the whole correspondence, but made no comment or resolution on it.¹⁴⁰ (A systematic search of the Times index reveals that although an arrest was made, the suspect was acquitted, and I have found no further mention of the case.¹⁴¹)

**Written guidance on secrecy**

During this whole period the advice in the BMA Handbooks remained simple. In 1923 the section on medical secrecy simply said, "a medical practitioner should not, without his patient's consent, voluntarily disclose information which he has obtained ... in the exercise of his professional duties".¹⁴² The 1926 edition added the explanation that "complete confidence" was needed to render proper medical service. It went on to advise that if the doctor suspects a criminal offence,
they should get in a consultant, and share the responsibility.\(^{143}\) By 1935 they expanded the advice further, staying that if there was risk to a third party, the doctor should try to get the patients to change their course of action or divulge the matter themselves. However, the advice continued, the doctor might need to “take the law into [his] own hands”, and that in informing others the doctor was ethically and legally “out on his own”.\(^{144}\)

Aitchison Robertson’s book was written before the main BMA debate occurred, and in Edinburgh, and thus events south of the Border, particularly since they related to the precedent driven English law probably had little influence on him. He saw secrecy as a Hippocratic ideal, and as the quotation given in the introduction shows, he regarded it as fundamental to medical work.\(^{145}\) Not all his views accorded with those to the fore in the BMA debate. He thought exposure of the name of the aborted was justified by the conviction of the abortionist, and a patient dying after abortion ought to make a dying declaration. In ‘the case of the syphilitic fiancé’, the patient should be put off marrying or the father of the bride informed. Robertson also discussed examining employees at length. He said that whilst a communication to an employer, in general terms about an employee’s illness, was “privileged” he also advised against allowing oneself to be called in by a “mistress” to examine her “maid”. One could only examine people and inform others of ones findings with the patient’s consent. It was best to avoid this situation altogether.\(^{146}\)

Hugh Woods’ chapter on Medical Secrecy in Sprigge’s volume bears traces of the BMA debate, and his experience in advising members of the MPS was evident: he always had an eye to the risk of litigation. Thus, whilst Aitchison Robertson appeared to stress consent in a more ethical sense, Woods underlined the important relationship between consent and the risk of litigation. His advice on secrecy was the strictest of any of these published discussions. His opening formulation was that “any man” who fails to keep confidences would be “rightly regarded as untrustworthy and dishonourable”, and that “Apart from legal compulsion the obligation of secrecy is absolute”. It was clear that he would have preferred it to be absolute.\(^{147}\)

“The unwilling medical witness” he said, “is a common feature of divorce proceedings, since his evidence will often do irreparable injury to the reputation of the patient”. His advice was not to let

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\(^{145}\) Robertson, *Medical Conduct and Practice*, 1921, p. 132.

\(^{146}\) ibid., pp. 132 - 136

\(^{147}\) Woods, Hugh, “Medical Secrecy” in; [Sprigge, et al.], *The conduct of medical practice*, (1927), 1928, p. 79.
anyone, especially solicitors, know what you knew beforehand.\footnote{ibid., p. 83.} He also commended “the safeguard of habitual reticence” since an exceptional silence is an obvious sign that there is something to hide.\footnote{ibid., p. 82.} The doctor thus needed to be on his guard when dealing with “employers, solicitors, insurance companies and others”, and should never give any information without consent.\footnote{ibid., p. 81} Breaking confidences could easily lead to suits for slander.\footnote{ibid.} As far as he was concerned, “the only circumstances in which any violation of the rule of secrecy should be contemplated are those which may sometimes occur when the maintenance of secrecy would allow a crime to be committed which could have been prevented a departure from the rule”. Even in this situation, the doctor should warn the patient.\footnote{ibid., p. 80.}

It is striking that Woods, whose background was in medical defence, is, of all those writing after Birkenhead’s attack, perhaps the most strict in his formulation of secrecy, the most energetic proponent of consent in all situations and the most clear in his warnings about suits for slander. A much more avuncular position was taken by Hawthorne in his \textit{Practitioner} article of 1936. Interestingly he stressed that the difficulties in deciding issues of secrecy and in whose interests to act underlined the need to have membership of a defence organisation.\footnote{Hawthorne, ‘Medical Ethics’, 1936.}

\textbf{Discussion}

Tact, delicacy and regard for the patient’s reputation converged in a traditional notion of medical professional secrecy. This principle, whilst widely endorsed was, at times, overridden by the Courts (in demanding evidence) and Government (in requiring the notification of diseases). These exceptions appear to not to have been contentious until the 1910s and 20s, when these tensions hardened into ideas of a far more absolute kind. Building on a generic sense of honour, doctors, despite their evident disagreements over what such a sense might dictate in certain situations, felt that an absolute principle of complete secrecy needed to be enshrined in law and legal precedent. Why did this occur?

The judicial interventions were of course specific triggers. Petitions for divorce were rising rapidly, and it would have been surprising if the judiciary had not sought out quick and simple ways of
settling these cases, which they appear to have regarded as a nuisance. These interventions followed the impressive and memorable Playfair case, in which the judge had upbraided the profession for insufficient regard for secrecy. Yet this rise in divorce rates was occurring at a time when other, deeper social changes were making themselves felt. Britain was emerging from a costly and traumatic War into a problematic peace, and the political and social order embodied in the “sham fight” between Liberals and Conservatives was breaking up as the Liberal camp disintegrated and socialism gained ground. More specifically the medical profession, and the model of individual medical care was beginning to be integrated with the machinery of the modern state - in National Health Insurance and in the setting up of the Ministry of Health. However, it was obvious that lawyers, not doctors, dominated government. In this context, it is not altogether surprising that an “unpopular” profession facing a challenge from another, more powerful one fell back on a notion and language of sacredness, tradition and honour, and fought hard to defend the standard it had raised.

The phrase “honour and interests” serves here, as elsewhere, as a useful guide. Generic honour was offended by breaking confidences, and professional status was weakened, it was thought, by the decisions of Avory, McCardie and others. But for all the insistence that public health would suffer if secrecy were routinely breached, many commentators at the time picked up on the usefulness of secrecy as a claim in the market place. Indeed the scheme proposed by Fothergill could be characterised as an attempt to advertise the honour of the whole profession in a particularly spectacular way. Riddell, commenting that the “Hippocratic” oath referred only to malicious gossip jibed that “if medical advertising were permitted, I am sure that a sign reading ‘Dr. Blank is a regular oyster; he never talks about his patients’ would be a valuable recommendation to the laity.” Le Fleming made a similar point, with no hint of irony, when he advised young GPs, “undoubtedly ... silence is golden, and a reputation for being as close as wax about your patients, so that not even your wife is in your confidence, is a very valuable asset”. Birkenhead also touched this nerve by asking why the argument for privilege should not be extended to the quack.

Another reason lies in the fact that these secrets were almost always sexual. The doctor was being asked to expose behaviour in his patients that was publicly deplored. Dawson, in particular, seemed most anxious that what he had learned in his own consulting room should not be revealed. Such revelations threatened the social order, and unless, with Crookshank, doctors were prepared to

154 Lawrence, Christopher, Medicine in the making of modern Britain, London, Blackwell, 1996.
155 Riddell, ‘Should a doctor tell?’, 1927, p. 442.
156 le Fleming, Introduction to General Practice, 1936, p. 94.
condemn the venereal and the extra-maritally impregnated outright, their silence implied complicity with a deeply entrenched social hypocrisy.

Here is it interesting to note the importance of consent in the discussion of secrecy. In medico-legal and medical defence texts consent for surgery of all kinds, and particularly for sterilising operations was strongly promoted in the 1920s and to a greater extent in the 1930s. However in terms of medical ethics it was most commonly mentioned in connection with the revelation of secrets. It is tempting to argue that the most dangerous thing a doctor could do to his best-paying patients at this time was not so much to harm them physically without consent, but to ruin them socially without consent. The injury in the latter case seemed as important to both doctor and patient as the possibility of physical harm, if not more so.

The furore, and the background ethical advice and adjudication, on secrecy demonstrates perhaps better than any other case the way in which professional honour could cut both ways. For Langdon-Down, honour was best defended by an honest statement of the legal and social constraints on confidentiality, whereas for the clique on the Council that overruled him only trenchant insistence on a new precedent would do. The ethical and legal guidance texts for doctors appeared to agree, but differed in vital details when it came to this question, just as doctors argued equally passionately to conceal the names of their venereal patients in court and to reveal them to the Ministry of Health. Simple manly honour was a poor guide to safe practice, as the enquiries to the CEC demonstrate.

Most striking however, was the thorough rout of the Dawson-Fothergill camp, by a strange mixture of Birkenhead's swingeing rhetoric, and the slow realisation that the profession was fighting a phoney war. By the 1930s it appears the fight to enforce secrecy in courts was long forgotten. The 1937 Matrimonial Causes Act, with its massive extension of the "medical causes", did not cause a reaction on the scale of 1920 - 22. Harry Roberts, commenting in 1937 on the swift rise in medical testimony for divorce said,

The present attitude of most doctors ... seems to me despicable. They usually salve their conscience by uttering a formal protest, and then proceed to throw the patient to the wolves of the law. This has happened repeatedly where the patient has been induced to attend a special clinic by official pledges of secrecy ... So long as the "responsibility" is shifted to the judge, the realities of personal and professional honour seem to matter little.157

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157 Roberts, Medical Modes and Morals, 1937, p. 53.
Chapter 13

Lay Complaints

As we have seen the Association regarded itself as defender of the honour and interests of the medical profession, but also as acting in the public interest. It was a highly visible organisation, and it is therefore not surprising to find that members of the public came to the BMA with complaints about doctors. These were dealt with by the Medical Department under policies set or modulated by the CEC, who were reluctant for the Association to be involved in this work, except where the complaint appeared to them to be "useful". The CEC's involvement was intermittent and so little material on this important area of the Medical Secretary's work survives. What does survive brings out further important points with a direct bearing on the main theme of this work: the involvement of the Association in adjudicating the rights and wrongs of doctors' behaviour and the relationship of the profession to society as a whole.

Picking and choosing

The CEC considered lay complaints in respect of certification in 1917. Certification was a great concern, and took up a large part of both Squire Sprigge's volume and a significant section of the BMA's 1926 Handbook. The GMC dedicated a whole section to the subject in their Warning Notice. It stated that "any registered practitioner ... shown to have signed or given under his name and authority any ... certificate, notification, report, or document of kindred character, which is untrue misleading or improper ... is liable to have his name erased from the Medical Register." Certificates were the preserve of the registered, and maintaining the integrity of these documents was part of maintaining the position of the profession in society.

The CEC were concerned by a complaint by the Clerk of Staffordshire County Council, received in 1917, which stated that a doctor had furnished a certificate for a school child with a cold, without seeing her. The doctor concerned was warned that he should comply with the GMC's guidance and only issue certificates for patients he had seen. The committee decided to review complaints by

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1 Sprigge, et al., Conduct of medical practice, 1928, 139 - 74.
3 GMC, Warning Notice, (1923).
4 CEC s/c, 3.4.1917.
members of the public, and asked Cox to write a report on the subject. Cox noted that complaints about certification were rare, but sadly did not detail other types of complaint. The committee decided that the Association could not deal with complaints about doctors who were not members. In the case of members they decided that the question of any action should,

depend upon the nature of the complaint; if it appeared that any useful purpose would be served by communicating with the Member in question that course would be taken, but otherwise the complainant should be informed that the Association does not recognise that it is its business to deal with complaints by members of the public against members of the Profession.

Thus the committee decided that the Association should only concern itself with complaints that seemed to them to be “useful”, and set out no procedure, beyond “communicating” with the doctor, should this be the case.

Anderson’s discomfort

This policy, as with so many others, was adapted to some extent by the Office, but by 1927 Anderson complained to the committee that the system was a cause for concern. We quite frequently”, he said, “receive letters, of which the appended one ... is an excellent example. ... a restrained and moderate statement from or on behalf of a person who considers himself to have been badly treated by a doctor”. It is not difficult to see why the case had prompted Anderson’s approach, but it must be noted that it is possible that a doctor had written the letter to the BMA. It involved a confinement in the Banff area of Scotland. The doctor complained of had undertaken to attend the delivery, having previously been “specially consulted in a grave case”. However, when the patient went into labour he had been telephoned twice through the day to no avail, and when contacted for the third time, had refused to attend, asking the husband, “what business had he to do with it” and calling him “a silly ass”. The services of another doctor were obtained, but the child was still-born. The ‘anonymised’ version of the letter, concluded, “Dr X’s alleged failure was most reprehensible and Mr A hopes that the Association can take such steps as will bring the serious nature of Dr X’s alleged neglect home to him.” It is rather sobering to reflect that this was presented as an “excellent example” of a type of “frequent” complaint.

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5 Memorandum, CEC 8.6.1919. Deliberation on this topic appears to have been badly held up. There is no indication as to why this occurred.
6 CEC, 8.6.1919.
7 letter, quoted in memorandum, CEC s/c, 22.3.1927. The memorandum simply stated that the writer of the letter had “been consulted by the patient’s husband”.
8 ibid.
Usually the Office replied that it was not the Association's business to judge such cases although they might sometimes suggest "legal remedy"). Anderson went on,

this may be the best we can do, but I do not feel comfortable about it. We are more and more in the public eye; we always claim that though we exist primarily to look after our interests of the medical profession, we also endeavour to maintain its honour. When we are attacked in the press and think it advisable to reply, we profess our belief that the profession exists for the interests of the public and that the individual doctor, by adherence to tradition, always puts the interest of the patient first. To people who know of this attitude of the profession it seems strange that we should have no way of helping them in a matter which they think affects the honour of the profession, through the reputation of one of our members. To suggest that they take the matter to court is a course which, if followed, our members would not thank us for, and yet that is really the only suggestion we can make to a person who tells us that, professing the principle we do, we have no right to wash our hands of all responsibility in such matters. I wonder if the Committee can think of any way in which we could more adequately fulfil our duty in such cases as these both to the profession and to the public.9

The sub-committee had a "general discussion" on the case and general problem, and decided to consider it at a full committee meeting.10 Their interim memorandum stated that whilst in criminal or damages cases they could not change their policy to 'leave well alone', they felt "there might be certain classes of cases ... which could be considered by the Association provided that the position of the practitioner affected was safeguarded." They could only deal with members, and only those who agreed to a "voluntary arrangement". They did not feel they could "impose a rule that a member must ipso facto agree to answer to a tribunal of the Association a complaint made by a lay person". There were doubts as to whether this would deprive the member of common-law rights, and lay the practitioner open to prejudice if the case went on to litigation.11 In the event, "after careful consideration" the CEC felt "unable to suggest any machinery which could be set up", although they do not appear to have ruled out the possibility of looking into a case if it was ‘appropriate’.12

The Medical Secretary's Office continued to operate an informal procedure, aimed at preventing litigation. This did not always work, as a case in 1928 demonstrated. A Miss O'Brien had come to see the Medical Secretary "full of a grievance" (the nature of which was never mentioned) against Mr. Mortimer Woolf. Attempts to dissuade her from legal action failed, and so she was referred to

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9 Memorandum, CEC s/c. 22.3.1927.
10 CEC s/c 22.3.1927
11 Memorandum, CEC 17.5.1927.
12 CEC 17.5.1927.
Hempsons’. In the event she had consulted other solicitors who had instigated a case that was becoming acrimonious. Woolf had written saying that referring these people to Hempsons was wrong because it deprived members of the help of the Association’s solicitor. Anderson defended his actions and described his policy, pointing out that he had to act in what he saw as everyone’s best interest in difficult circumstances.

When I am approached, as I frequently am, by lay people making extraordinary statements about medical men, I do my best to reason with them, and frequently succeed in making them see that there is a professional side to the case which they had not appreciated. Sometimes this ... does not succeed and they declare their intention of taking legal advice. ... I have no hesitation in recommending them to see Messrs Hempson, because their knowledge of medical men and medical affairs is such that quite frequently their influence is enough to prevent the matter going any further. I should think myself failing in my duty to the profession if I allowed such people willingly to get into the hands of lawyers who know little or nothing about medical affairs and who would be probably more likely to take the matter into court...13

(It seems Anderson had his own way of categorising and evaluating the complaints and complainants.) When presented with this correspondence, the CEC simply thanked the Medical Secretary “cordially” for doing this work so well, but suggested that he no longer refer complainants to any specific solicitor, and that he warn the member of impending legal action.14

The Association almost became involved in adjudicating a complaint against a member in 1931, in an apparently ad-hoc decision to act with the agreement of the doctor involved. The member, Dr Williamson had been in charge of the case of a Mrs Burkmar, a paying patient at the Royal Northern Hospital. She had died, and her husband was upset by what he saw as inconsistencies in the handling of her case. The diagnosis had never been made clear, and was changed after her death to “cancer”. Yet, her teeth had been extracted for anaemia, thought to be due to pyorrhoea. She had lost weight and started bleeding from her mouth and [I infer] her stomach. Also the consultant had been away during the fatal phase of her illness.15

Dr Williamson provided the BMA with a report of her case that Anderson wanted to show to the husband, in order to try and placate him. Williamson felt that the husband “should [not] see this report for I think it would only result in further questions”. He hoped the CEC would convince him that “so far from there being neglect the very reverse is the case”.16 Anderson met Mr Burkmar,

13 Letter, Anderson to Woolf, in Memorandum, CEC, 13.11.1928.
14 CEC, 13.11.1928.
15 Documents in CMAC SA BMA D237.
16 Anderson to Williamson, 13.4.1931, in D237.
and showed him the report in April, commenting to Williamson afterwards, “it did not satisfy him, and this does not surprise me because I do not think that any reply will satisfy him except one which puts you entirely in the wrong.” However, it had emerged that the husband was refusing to pay the Hospital’s bill, and in view of the possibility that they would pursue him for fees, Anderson and the Chair of the CEC both felt that they could not proceed with the hearing.

Thus, whilst Anderson felt strongly that the Association’s duty would sometimes dictate that they should investigate complaints by lay people, in practice this never happened. Despite the reasonable concerns of the secretariat, the CEC did not feel that the investigation of these complaints was part of their remit in maintaining the honour and interests of the profession, or its ethical standards. Anderson felt it should be, and operated an informal system whereby complainants were dissuaded from legal action, either by himself or by reference to the Association’s lawyers, or placated as best they might be. As the next section shows, Hempsons’ were very unlikely to support a lay person bringing a complaint against a doctor.

Medical Defence

It has been beyond the scope of this study to look closely at the issue of malpractice and medical defence - a subject crying out for historical attention - however some comments should be made in relation to this theme. It is clear from the appearance of a multiplicity of defence organisations and the interest of the BMA in the late nineteenth and early twentieth centuries, that medical defence was seen as a vital professional project.17 The MDU contested 1,564 cases in the decade 1896 - 1905, of these 448 were libel and slander cases, of which 3 were lost, and of 267 cases of alleged malpractice, only two were not acquitted. Sadly Forbes does not give comparable figures for other decades although he does show that slander and libel cases almost disappeared, and that malpractice came to occupy 47.9% of the cases defended.18 Taylor felt that the malpractice suits would be far more frequent were it not for the existence of the Union.19 It was said that many cases were dropped when the fact of the doctor’s membership of a defence organisation was discovered, and William Hempson solicitor to the BMA and the MDU, was noted for his “vigour and firmness”. Forbes felt his “policy of ‘no compromise’ contributed a great deal towards making the young Union known and feared in legal circles.”20

17 Forbes, Sixty years of medical defence, 1948, pp. 4-7.
18 ibid., pp. 50 - 51.
20 Forbes, Sixty years of medical defence, 1948, p. 75.
On the other hand, the MDU during the whole of this period retained the right not to take up a case on behalf of a member, and only introduced liability insurance in the 1920s after vast damages were awarded in the case of Harnett v. Bond and Adam. Prior to this liability insurance had been thought to “lower the guard” of the practitioner. Competence and honour were linked in the advice of the BMA Handbooks of both 1926 and 1935 where consent was presented as a sensible defensive manoeuvre. The reader was advised that to undertake a procedure for which they were not properly competent was to invite disaster, and that they should think of the damage a poor outcome would do to their reputation. The advice on malpractice generally warned of the need to perform X-rays for suspected fractures, to ensure no swabs were left behind at operation.

Negligence was a common law legal concept applying to everyone and there were no statutory definition or specific laws or statutes relating it to medical practice. Practitioners were expected only to “act in good faith and with proper care, and that he shall show reasonable knowledge and skill. Not the highest possible attainments are demanded, but those which may reasonably be expected from a person holding a medical and surgical qualification. ... No practitioner is expected to be infallible”. Aitchison Robinson gave several examples of proven malpractice. These included a drunken practitioner who left a placenta in the uterus after delivery, causing the mother to die of sepsis, whilst another practitioner severed the child’s penis instead of the umbilical cord. A third was a forceps tear causing a loop of bowel to prolapse, which was then ligatured instead of the umbilical cord. Doctors, he said, were expected in law to perform with the “skill and diligence [of] a well-educated practitioner”. These examples of malpractice are so glaring they beg the question as to what lesser degrees of incompetence could be passed off in court under the cover of supportive medical testimony.

In the area of malpractice and medical defence then, doctors could expect to be supported by other doctors in court, and by a defence organisation. Importantly however this organisation could refuse to take up the case, and existed to defend the profession in other, wider senses. Doctors were enjoined to look to their reputations and consciences when deciding to perform a procedure. The “normative” rule of malpractice - that a practitioner need only act as a reasonable doctor of his

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21 ibid., p. 60.
24 Robertson, Medical Conduct and Practice, 1921, p. 145 - 7.
grade and experience would have acted - meant that only gross negligence and incompetence were
punished by the Courts.
Section III

Medical Ethics
in early twentieth century Britain
and after
Chapter 14

The BMA’s 1949 code and after: an Epilogue

In chapter 3, which described the work of the CEC in general terms, I set out the resistance of the committee to requests that they codify the principles and precedents built up during the time the committee had been in existence. I also briefly outlined the circumstances in which they produced a small booklet summarising their idea of suitable conduct and guidance for doctors when requested to do so by the Board of Deputies of British Jews, and the British Dental Association. The influx of refugee doctors from central Europe and Germany in 1932 - 33 had already placed considerable strain on the carefully cultivated world of medical professionalism. Lord Dawson, by then President of the RCP, felt the British profession should be protected from overcrowding, and attempts were made to limit the rise in the registered profession by stipulating that these doctors must pass British qualifying examinations. Controversy arose when it was perceived that some licensing bodies, particularly in Scotland, were passing too many immigrants too readily. It is particularly striking that it was only when a request came to instruct large numbers of doctors whom the BMA could not expect to understand a culture of medical practice often referred to as particularly British that they chose to codify to protect that culture. In my initial examination of the CEC minute books for the years 1938 - 1948, I noticed that German Jewish or central European names appeared with noticeable frequency.

After the war the committee felt that the disruption caused by the war was such that younger doctors had had poor exposure to traditional medical ethics. They “considered the necessity for, and best method of bringing to the attention of new members of the profession the accepted ethical codes of professional conduct” and decided to adapt a lecture given by N E Waterfield. The committee later decided that all those who had qualified during the years 1939 - 1949 should

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1 CEC, 20.12.1938.
3 Discussions of dichotomy as a foreign vice, and the language used to disapprove the American advertisements of Fleischman’s yeast are examples.
4 Council, 18.1.1939
5 See BMJ B/54/2/52 - 62.
6 CEC, 28.12.1948.
receive the code. The code itself was a remarkably short and rather approachable document, which essentially summarised the work of the committee since 1902.

**Ethics and members of the Medical Profession (1949)**

The preface to the booklet explained that the "standard" of medical ethics had been disrupted by the War and that the book was intended primarily for those who had qualified in the last ten years. Thus these doctors were construed as untutored and unacclimatised to the pre-war world of medical ethics, just as the refugee doctors had been. "The medical profession" it began, "occupies a position of privilege in society because of the understanding that a doctor's calling is to serve humanity under all conditions and because in the past members of the profession have built up a tradition of placing the needs of the patient above all else." Next the reader was informed of his duties to maintain this position, in words that would have had great resonance for the more conservative minded members of the profession this time.

On admission to the brotherhood of medicine, every new member succeeds not only to the benefit of its special place in society, but also takes upon himself the duty of maintaining this high position. The justification for the freedom of medicine lies in the hands of those who practice it.

The preamble then set out a liberal précis of the Hippocratic Oath, stating that "today these rules still hold good ... to command the respect of his patients and the public should be the aim of every doctor. The strict observance of basic ethical principles will enable the doctor to attain this end, which is necessary to good practice and successful treatment." These formulations contain a remarkably neat summary of the ethical thinking this thesis has examined.

The booklet next described the constitution, powers and procedures of the GMC, before giving a précis of the latest version of their Warning Notice, which still contained the old categories: certification, "covering" and association, covering unqualified midwives, the dangerous drugs acts, and advertising and canvassing.

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7 Council, 11.5.1949.
8 BMA, Ethics and the Medical profession, 1949, p. 1.
9 ibid., p. 2
10 ibid.
11 ibid., p. 3.
12 ibid., pp. 3 - 7.

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The second section of the book was entitled "Code of professional conduct", and described its rules as "customs and ethical rules" pointing out that situations constantly arose which no rule had anticipated in detail, and that the code was thus presented to "serve to illustrate the principles of behaviour". It also alluded to the code under preparation by the World Medical Association. The code thus covered only those principles not already contained in the Warning Notice section.

Firstly doctors were instructed not to set up in practice in areas where they had served as assistants or locums, or where negotiations over partnerships had broken down. Familiar advice on doorplates was given, spelling out that statements of speciality, beyond the letters indicating higher qualification could disrupt the referral of patients via their general practitioner. Doctors were told of the rules on consultation, and how to obtain them from the BMA, and instructed to visit their medical neighbours when they first arrived in an area. Familiar advice on treating patients of other doctors was set out. Dentists were to be treated rather like registered medical practitioners, and consulted and communicated with where joint care was required. A long section dealt with direct and indirect advertising, and set out the limitation of doctors' participation in the media. Doctors could be included in telephone directories, but only described in the same terms as their doorplates. The section on secrecy marked the greatest shift in emphasis, for whilst it set out that doctors should give information only where required by statute or under instruction from a judge, the penny had finally dropped that the Oath did not forbid any breaches in confidentiality. Doctors were told there were situations where it would be unethical not to inform third parties of the facts of case.

Termination of pregnancy was described in exactly the terms of the advice given in 1903. Doctors owning nursing homes were to disclose this to patients they sent there, and homes offering medical treatment were to be advertised only in the medical press, and then only soberly. Lastly dichotomy was stated to be "improper ... and ... illegal". Thus the BMA's 1949 code was, despite its gloss, a remarkably backward-looking document.

The Declaration of Geneva

At much the same time as CEC was drafting its code they also considered the WMA code and Declaration of Geneva. This oath, they suggested should be compulsory for all graduating medical students. The oath itself took its form and language in part from the Hippocratic Oath, but added important clauses about human rights, independence from political and racial bias, and replaced the specific injunctions about poisons and abortion with a statement committing the doctor

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13 CEC, 8.3.1949.

14 CEC, 25.4.1950.
to uphold the sanctity of life. It also drew on the language of medical solidarity and honour to a significant degree, and it was thus intermediate in tone and content between the kind of ethics set out in the BMA code, and the new ethics centred on human rights set out in the Nuremburg Code.

"At the time of being admitted as Member of the Medical Profession

I solemnly pledge myself to consecrate my life to the service of humanity
I will give my teachers the respect and gratitude which is their due
I will practice my profession with conscience and dignity
The health of my patients will be my first consideration
I will respect the secrets which are confided in me
I will maintain by all the means in my power, the honour and the noble traditions of the medical profession
My colleagues will be my brothers
I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient
I will maintain the utmost respect for human life from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity

I make these promises solemnly freely and upon my honour”

... and after

Much work remains to be done to ascertain if the conservatism apparent in the BMA’s 1949 code remained a feature of the Committee’s work. Homer demonstrates that until the reforms of the Committee’s work and remit in the 1980s, its function within the Association changed only very slowly.16 Hugh Clegg, editor of the BMJ, commented on old-fashioned medical ethics in Medical Ethics, a volume edited by Maurice Davidson in 1957,17 portraying the pre-war canon as “etiquette” and implying it was obsessed with status and form.18 Certainly progressive changes were occurring in the world beyond Tavistock House.

Peter Flood, a catholic priest, produced a series of volumes on medical ethics in the 1950s that concerned with medical practices that touched on catholic theology such as contraception, abortion and euthanasia.19 John Marshall, a neurologist working in collaboration with a catholic priest published a book on medical ethics in 1960. He pointed out that whilst “the code of conduct in medical practice was at one time a matter of common agreement among doctors, irrespective of

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19 Flood, Dom. Peter, New problems in medical ethics, Cork, Mercier, 1953 (I), (II), 1956 (III).
their particular persuasion or philosophy of life” the modern trend toward “subjectivism" produced “widely differing opinions” on “important matters of life and death ... sterilisation, abortion and euthanasia”. Marshall felt “a restatement of the traditional Christian approach to these problems which is founded on natural law and revelation is therefore required”. A catholic canon of medical ethical writing was at the vanguard of a change in medical ethics that was to put moral reasoning first and convention second.

Roger Cooter recently suggested “the voice of God” as possibly one of the most important transformative trends in post-war medical ethics. He identified other trends as being the growth of various civil rights and feminist movements, the ecological perspective, and the challenge to the establishment of the late 1960s. More recently consumerism in its reconfiguration as a set of “rights” and political challenges to the hegemony of the professions have been important. Cooter also highlights the place of the professionalisation of bioethics itself in the apparently sweeping changes that have transformed medical ethics.

Some ethicists themselves have written about this change. For instance Albert Jonsen, looking back on his career in 1990, included himself amongst the anthropological and sociological “doctor watchers”, but also reveals himself as one of a new ‘profession’. He said,

Decorated only with degrees in philosophy and in religious studies, I migrated into medical education, where I have been professing medical ethics for two decades. I follow the little party of doctors, nurses and medical students to the bedside of very sick people. I read patient’s charts, talk about patient’s ills, participate in discussions about patient’s fates. Although I eschew the pretensions of white coat and beeper, I admit to some gratification at being “inside”. More than that, I believe that I have some right to be there and that my being there does some good to doctors and patients alike. ... My work is medical ethics.

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21 Many other titles on ethics appear to have been produced by writers with catholic connections (highlighted in bold).


My professional title authorises me to teach “ethics in medicine”. I read and write about ethics. I have studied ethics, both as moral philosophy and as moral theology.

Steven Toulmin has argued that medical changes and advances had “saved the life of ethics”, but interestingly his own experience of ethical work suggested that the principles these new experts were trained to bring to bear were not as important as simple common sense and consensus.

Changes in the content and character of medical ethics adjudication has also been driven by two more factors. Firstly, innovations in medical technologies that cut across hitherto “natural” boundaries such as conception, implantation, intra-uterine development, birth, terminal illness, and hitherto untreatable diseases. Secondly 1948 was an ethical watershed in another important way. The Nuremberg Trials of Nazi war criminals revealed widespread experimentation on prisoners in concentration camps that shocked the world. The subject of the Nazi doctors became instantly and permanently fascinating, calling into question the nature of medical paternalism and ethics. These trials exposed acts of inhumanity that have cast a long shadow, discernible in the adoption of the Helsinki Declaration on human experimentation in 1964, and the famous whistle-blowing expose of abuses in British medical research by Maurice Papworth in 1967. The history of post-war medical ethics appears at times to be a string of reactions to abuses of power such as the Tuskegee experiments, and terrible suffering, such as the Quinlan case.

The BMA felt moved to investigate the involvement of doctors in torture in the 1980s, a subject that whilst it is of enormous importance had little bearing on the professional lives of its members. In this respect the report of this working party is part of a long history of published reports of by the BMA aiming to inform public debate and promote its own image. The title of this book Medicine Betrayed brings us round full circle. The title was not “Patients betrayed” or “Humanity outraged”; it was the profession itself that was dishonoured by the actions of these doctors.

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Indeed modern medical ethics begins to look like a tale of two professions, one old and one new. The one, medicine, increasingly distrusted (and distrusting at times of), the other, “bioethics”, setting out to renegotiate the powers and ideals of medicine within a changed and changing society. Reaction against the profession of bioethics and medical ethics is exemplified in a recent *Lancet* editorial that characterised it as an “ethics industry”, carried on in academic departments producing work that was “quaint and irrelevant”\(^\text{31}\). Rather more thoughtful reaction is exemplified by the recent comments of a geriatrician, reviewing a book on assisted suicide in the *TLS*.\(^\text{32}\) He began his review, which appraised the book in question very fairly, with the arresting sentence, “The flood of publications on medical ethics is so copious that any physician wanting to keep abreast of the literature would have to abandon the practice of medicine.” Tallis went on to assert that there seemed to be an “unbridgeable” gap between ethical literature and medical practice, that most of the problems discussed rarely faced practising doctors, that medical ethical principles were contradictory when applied to everyday dilemmas, and that no doctors in his acquaintance read, much less actually used this literature to solve their ‘ethical’ problems.\(^\text{33}\) Whilst much could be said in criticism of pre-war medical ethics, these comments would certainly not have applied.

In my concluding chapter I shall characterise pre-war medical ethics as a social and professional phenomenon, in the contexts of both what went before, and what was to follow.

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Chapter 15

Conclusions

The BMA's CEC is arguably the single most informative window onto early twentieth century medical ethics available to historians. This is not only because of accidents of archival preservation and access, but largely because the BMA was the only medical organisation that attempted to regulate, guide and represent doctors from all parts of the profession, and which had its policy decided by an annual meeting of democratically elected representatives.

Once it had reformed itself in 1902, the BMA was able to take on an effective role in adjudicating and advising practitioners on medical ethics for the first time in its history. The doctors involved in its medical ethics work were, broadly speaking, a representative selection of practitioners who could be expected to have the time and security to devote to such activities. Since the CEC served the membership of the Association, it was engaged in a much fuller dialogue with ordinary doctors than any other body with powers or responsibilities in this area. The BMA despite its relatively poor links with the Royal Colleges drew on both the content of previous codes, and the forms adopted by older medical organisations to structure and inform their ethical work. The CEC became the latest in a number of professional tribunals with conduct jurisdiction, and the BMA pursued an active policy of influence and infiltration with regard to the GMC, the ultimate professional court. As we have seen, the decisions and documents produced by the committee were broadly consistent with the contemporary literature - though it must be remembered how little of it was produced by authors without any direct or indirect connection to the committee.

In this concluding chapter I shall firstly set out the broad historical framework within which I propose medical ethics can be understood, and use this to inform a description of the main characteristics of the medical ethics exemplified by the work of the CEC.

Central Thesis

I propose that medical ethics can be best understood historically as an adjudication of right and wrong behaviour in medicine, and, with French, that its underlying function can been seen as securing the place of the medical profession in society.¹ This idea has been applied to, and borne

out by, a set of materials entirely removed from those French was discussing. Lastly I propose that the behaviours discussed in medical ethics during the early twentieth century all had a bearing on aspects of the boundary between profession and those outside it, and created a special behavioural and cultural ‘space’ in which medical practice could flourish. It did this by regulating the interactions of the members of the profession, by setting out the characteristics for inclusion and exclusion from the profession, and by attempting to control interactions with those outside the group. Indeed whilst medical politics can be seen as the promotion and maintenance of the profession’s agenda using the tools political influence and persuasion outside the profession, medical ethics can be seen as serving many of the same ends, but using the tools of codification, advice and adjudication of doctors’ own conduct.

How then did medical ethics between the turn of the century and the Second World War work to define the boundaries of the profession and what kind of space was created within them? I shall examine five key aspects of this boundary: law and legality, inclusion and exclusion of doctors, quacks and auxiliaries, the interaction with trade and commerce, and relationships with patients. In doing this much of the space will already have been described, but I shall go on to describe it in more detail, before looking beyond the main time frame of the thesis. In summary I shall return to the pivotal phrase, “honour and interests”.

**Ethics and the boundaries of the profession**

**Medical ethics, Law and the *lex non scripta***

As the literature, and some of the events set out in this thesis show, doctors’ conduct was subject to general and specific laws, and society placed increasing numbers of statutory duties on registered medical practitioners.\(^2\) Saundby gave the principle of “rendering unto Caesar” as the third principle of medical ethics. There was an important overlap between questions of medical jurisprudence and medico-legal matters and the problems dealt with in medical ethics. Some preferred to combine these matters as “practical problems” or “conduct of practice”, thus leaving “ethics” on a different level - not necessarily reducible to written principles. Ethics could be seen as based on custom and tradition, and concerned with virtues, characteristics and conventions governing conduct, rather than written rules, or more specifically laws. Thus for instance we see dichotomy characterised as improper, dishonourable, and illegal, rather than as being simply illegal.

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\(^2\) For many years in the early twentieth century the *Medical Directory* carried a list of laws relating to medicine. The list became noticeably longer as the century progressed.
There are obvious parallels between British medical ethical ideas and conduct jurisdiction, based on
tradition and custom, and the English legal system based on precedent and Common law. Such an
approach meant that precedent could change, and norms of behaviour evolve rather than having to
be constantly revised in the way which a formal code of medical ethics would have required.
Furthermore, medical ethics, particularly in the hands of the BMA relied on the adjudication of a
“jury” of “peers” in the form of local and central ethical committees, considering cases much more
frequently than codes. It is also possible that these doctors approached such cases of problematic
behaviour as they would problematic physical or mental symptoms in their clinical work.

Discussions of clinical method at the time rested on ideas of irreducible experience, skill, and a
weighing up of the patient’s problem in the context of their “environment”. The ideals of careful
case-by-case medicine can be seen mirrored in the reluctance of the CEC to consider hypothetical
cases or problems. Doctors were seen to be competent to deal with this kind of task, in and of their
own professional status, although some of course were recognised to have particular skills or
experience.

However there were instances in which written rules were thought to be necessary, and of these
Consultation, and Branch and Division ethical procedure were the most important. Crucially, these
were often presented as distillations of customs and traditions. Aside from decisions in individual
cases, and their codificatory documents, what the CEC most often produced were expressions of
opinion, resolve, disapproval, objection or recommendation. If, in the end ethics boiled down to
two questions, “does your conscience permit it?” and (more forcefully,) “what do your colleagues
think of it?”, and it was on the latter point that the Committee helped inform practitioners.

Moreover, it was usually enough for the Committee to express this type of opinion, and leave it
down to the practitioner to decide how to proceed. The dynamics of the professional situation and
the specific punitive machinery of the Association were such their guidance could be expressed in
less than absolute language.

The CEC was not entirely addicted to casuistry, and was capable of enunciating principles in
relation to difficult areas of policy. Indeed it was their formulation of such principles in areas like

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Practice*, 1936. Also see, Lawrence, Christopher, ‘Still incommunicable: Clinical holists and medical knowledge in
interwar Britain’, in Christopher Lawrence and George Wiesz, (eds.) *Greater than the parts: holism in biomedicine 1920

4 De Stynap, *Medical Ethics*, 1890, p. 39, “there is no tribunal other than [the doctors] own conscience”, and p. 54, “Let
conscience decide!”.
professional secrecy and advertising nursing homes that brought the CEC, and the Council and ARM into collision. These disputes can be characterised as being over how to balance custom and usage (and whose custom and usage) against principles (which themselves could be seen as customs or traditions). Within these disputes both sides would be acting as they saw best to uphold the "honour and interests" of the profession, and it would be a mistake to characterise the different parts of the Association as embodying different medico-political or ethical stances. Thus in the secrecy débâcle the Council and the ARM took the more ‘principled’ stand, whilst in the wrangle over nursing homes the CEC consistently pushed the principles of non-advertisement and disclosure of interest.

In the context of this discussion it is pertinent to return to Baker’s contention that medical ethics became enshrined as medical jurisprudence in Britain after Percival. It is true that in contrast to America little energy was put into writing codes until later in the twentieth century. That said, medical jurisprudence had a meaning quite distinct from medical ethics by the later nineteenth century and British medical ethics was heavily reliant on the “lex non scripta” and used cases rather than codes. The legalistic implications of the term jurisprudence must therefore be qualified, his characterisation is only accurate if the true depth of the casuistry and reliance on ideas of tradition, culture and custom within the adjudicatory frameworks are appreciated. Only further research would reveal if the characterisation of American medical ethics as codificatory is similarly skewed.

Inclusion and exclusion

Broadly speaking, inclusion in the profession of medicine was dependent on qualification, whilst exclusion was dependant on behaviour. The ancient colleges set various standards of qualification, but most included non-medical attainments in their criteria. Alongside these gentlemen the registered profession contained large numbers of practitioners with licences, but little in the way of wider learning. A few of those that failed to live up to certain standards of conduct were excluded; either by informal ostracism, by formal boycott, or by expulsion from the Association or even the profession. Although only a minority of erasures from the Register involved ethical offences, (of which advertising, covering, were the main examples,) rather than civil or criminal wrongdoing, the possibility of exclusion was important, and influenced doctors’ behaviour irrespective of the actual numbers of erasures.

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Medical qualification could not confer orthodoxy by statute, although those who took up unorthodox treatments whilst on the Register placed themselves in a difficult position. It seems likely that these practitioners were watched more closely than others for signs of wrongdoing, and may have been excluded from the usual round of consultation and referral. Thus even the Homeopathic Directory was construed for a time as an unethical advertisement, and the publications and other public appearances of these practitioners tended to be construed as offences against medical ethics. There was of course a tension between those who were liberal enough to tolerate this kind of dissent, and those who demanded orthodoxy. For these latter, a number of ethical constructs were available to “tidy up” the ambiguity of the professional boundary in this respect.

Not that the BMA was quick to push practitioners out. The CEC set out, in most instances, not to condemn practitioners, but to advise them, and the general ethical rules stipulated that disputes were best settled amicably and quickly. In fact since the Committee’s initial approach to practitioners was often ask them to explain themselves there was a difficult conflict between what Charles Hawthorne described as the “parental” and the “judicial” approaches, saying in a letter to Anderson,

if ... it is decided to pursue a parental policy in which the individual concerned may be remonstrated with and brought to good works, we cannot contemplate judicial proceedings on the same issue at a later date ... it would be manifestly unfair to obtain admissions and evidence from the erring child and [then] to use [them] against the prisoner in the dock.  

Quackery and medical auxiliaries

Behind the ethical rules, deliberations and ideas, lay a set of assumptions or ideals, which the rules themselves then underpinned and promoted. These could be described as being; that the profession was liberal, gentlemanly, disinterested, competent, scientific, altruistic, paternal; that it had the patients’ interests at heart, and clearly understood how best to serve them; and that those outside the profession were venal, fraudulent, ignorant, incompetent, money grubbing tradesmen and hucksters who were beneath contempt. Yet doctors were, like everyone else in society, subject to laws, economic conditions, the forces of approval, disapproval and reputation, and like many of their fellow creatures were competitive, self-interested, divided amongst themselves, and flawed. The issues tackled by the CEC all had a bearing on these failings, even if their method of resolving them, their conclusions, or their underlying assumptions were at times called into question.

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6 Hawthorne to Anderson, 17.7.1929, in CMAC SA BMA D151.
The 1858 Act, whilst defining the boundaries of the profession in statutory terms, did not abolish the practice of medicine outside it, and the profession was thus left with comparatively weak statutory instruments to use to suppress these competing practitioners. The ethical rules of consultation, and the GMC's warnings on Covering and Association acted to reinforce the boundary, by banning professional association with unregistered practitioners in anything other than a supervisory capacity, creating a kind of medical apartheid. Furthermore doctors were discouraged from behaving in ways designated as quackish. The unqualified were seen as part of a commercial, trading culture that the profession had set itself to rise above. The boundary generated its own set of self-fulfilling assumptions about the differences between doctors and the unqualified, unregistered and others.

**Medicine and Trade**

The ethics of advertising were a prime example of this. By hardening what was a widely held distaste for advertising into an absolute, distinguishing disciplinary issue the profession set up mirror caricatures of itself and those outside it. Doctors of course, still had to operate within the market economy, although the much-resisted advances of State medicine were in many ways protecting them from this risky setting. The opposition to first National Insurance, and then the NHS look a little anomalous from a modern perspective, particularly in this regard. (The ideal was that doctors should do well, but only by excellence in practice. The distinction between rising above the market, independent, free and wealthy, and cosseted in the safe limitations of a state service was an important one.) The rule that doctors should not advertise was an important distinction to make in the clamorous marketplace. It was however, something of a peacock's tail of affected gentility that many doctors could ill afford before the advent of state medicine which helped to draw them securely into practice, particularly at the outset of their careers.  

**Patients**

Patients were assumed to find their way to the doctor of their free choice by mechanisms that were never clearly stated. Some writers simply stated that reputation should be the reason for the patient's seeking out of the doctor, but it seems unlikely that all patients selected their doctor for reasons that writers on medical ethics would have approved. Once a patient and doctor were

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7 I refer to the evolutionary concept that some creatures develop characteristics that are physiologically costly to maintain to draw attention to their fitness.

8 Anne Dibgy has argued this in a paper which will form a chapter in, Hardy, Anne and Keir Waddington, (eds) *Financing British Medicine* (forthcoming).
engaged in their relationship, the law assumed a fiduciary basis, and ethics simply stated that the
doctor should always, indeed *did* always do what was in the patient’s interests. This was almost the
definition of the doctor, a given, a basic proposition, which was almost never questioned until the
matter came to Court as a claim of negligence or malpractice - which it rarely did. Doctors were
certainly discouraged from reflecting negatively on the performance of their colleagues. Patients
themselves were seen to have a responsibility to treat their doctor fairly, not to consult quacks and
to break the therapeutic relationship formally, if at all.

Medical ethics, and specifically the rules on advertising, supersession, consultation and secrecy
underpinned a model of doctor-patient relations that was continuous, confidential, non-commercial
(although ideally well-paid) and in which the patient had full confidence in their doctor. Indeed
adverse comment on an attending practitioner was often presented as prejudicial to the patient’s
welfare since it would undermine the all important confidence needed for therapy (or lack of it) to
be effective. The confidentiality of medical relations underpinned a tacit contract that moral
judgements would not be made by the doctor about his patients in public. Beyond this medical
ethics did not intrude; doctors either alone, or in consultation, were seen to be competent judges of
all questions relating to medical practice.

**Within the Pale**

The tradition of medical ethics condensed by Percival, revised by de Styrup, and carried forward by
the BMA, aimed to promote a harmonious world within the medical profession. Within the
professional boundary actions were to be guided by “The Golden Rule”, and characterised by
gentility, disinterest and urbanity. At least that was the ideal. Doctors of course were often
competing for patients, and since they differed widely in social origins, educational background,
expertise, character and wealth there was plenty of room for disagreement and division.
Consultation ethics were, in the hands of the BMA, particularly important in underwriting the
notion of a unified profession. This defence of the attending practitioner and the refusal to
recognise a “class of consultants”, along with the financial leg-up of NHI, must have helped
preserve general practice in Britain. It is therefore ironic that with the advent of the NHS and the
‘gold-rush’ for consultant status, this resulted in the division of the profession for once and for all.  

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9 This is not a factor discussed by Honigsbaum in, Honigsbaum, Frank, *The Division in British Medicine; a history of the
Divisions along class lines within medicine were also problematic because those with the highest status had least to gain from the kind of solidarity the BMA was hoping to promote, and that its ethical work aimed to engender. Thus Cox, son of a foreman, addressed a meeting of Harley Street’s Division of the BMA in 1922, and upbraided highly successful practitioners who refused to see that the profession stood or fell as a whole, whilst praising those who gave their time, expertise and leadership to benefit their less notable brethren. The transgressions of Lane, Bruce Porter, Williams and others were particularly grave since not only did they not need the ethical rules they flouted, but worse still, they also represented the social goal of the whole profession. Cronin put this beautifully in a very accurate caricature of Lane (with shades of Crichton Browne). “Many were the muttered grumbles amongst more legitimate healers that Sir Rumbold should have been scored off the Register years ago: to which the answer manifestly was - what would the Register be without Sir Rumbold?”

The image frequently used to describe the ideal of intra-professional relations, aside from the golden rule, was “playing the game”. Significantly, this refers to a ritualised competition, in which sportsmanship rather than naked ambition is the dominant feature. The rules should be known by all players, and appeals to rules books or umpires should be few, and on leaving the field all should shake hands and think well of their opponents. The game of course was to practice successful, respectable, profitable medicine, but even on the ‘new pitch’ provided by Lloyd George, it was not one everyone could hope to win. Two of the CEC’s important roles were the containment of disputes between players, and the subtle adjustment and communication of the rules.

Not that just anyone was allowed to play, and those that attempted to join in without being members of the club were carefully excluded. The rules of the cruder competition between medicine and the unregistered medical sector were only partly written by the profession, but there was no sense that the profession was prepared to be a good loser. Or to use another metaphor, medicine was at once a closed shop, and also intended as a kind of special open space in which virtue would automatically rise.

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11 Here I am thinking of Crichton Browne’s directorship of Bovril in the 1920s.

Medicine and the public

Just as doctors were instructed, and simultaneously assumed, to have the patient’s best interests at heart, the BMA assumed that its interests and the public’s were to be served by essentially the same means and ends. What was good for the profession was held to be good for society. However, although this basic belief was still held in 1948, it would be wrong to assume that no changes had occurred.

Two big shifts had an impact on the medical ethics of the day. The Edwardian period was characterised by a kind of class warfare, in which doctors organised themselves in the manner of trades unions, with the vital distinction that they were “brethren” not “brothers” like their working class opponents. The power they were attempting to break was not that of a capitalist elite, but that of working class self-help and self-organisation. This was determined class action of a particularly ruthless kind, and the medical ethics and politics of the time reflected this. The problematic organisations in interwar medicine were clinics and commercial treatment centres, not friendly societies, and their clientele was much more middle than working class. This, and the financial involvement of doctors in these organisations, meant that a much more difficult path had to be trodden in attempting to hold true to the kind of medical world the BMA wanted to foster.

After the War, in the context of steady social change, and in the wake of the Coventry case, a new kind of relationship with wider society emerged. The Association became keener to court public opinion, and more mindful of it. This keenness partly developed out of the ‘PR disaster’ of 1925-27, during which a progressive body of influential figures argued that the profession resembled nothing more than a conspiracy and a monopoly. Edwardian medical politics and ethics did nothing to dispel this impression, and indeed may have created it and thus medical ethical rules that attempted to mark the profession out from the unqualified came under attack - particularly those on advertising and covering.

The rules on taking over another doctors’ patients, and the ethics of consultation were also rather unpopular with patients who either needed or wanted to change doctors, or to seek a second opinion without informing their current medical attendant. The notion of secrecy was particularly important since this was one ethical principle the profession felt it could rely on the public to applaud. To find this principle challenged in the Courts by another profession seems, for some, to have been particularly painful.
Many of these themes were summed up by Langdon-Down in a memorandum on the decisions of the CEC. His statement contains a kernel of social truth; the profession’s very existence rested on its ability to demonstrate convincingly that what it had to offer was of benefit to both profession and society. Yet what is most striking here is the straightforwardness of the assumption. He felt that “references to the welfare of the public or public policy” were superfluous in their opinions, because I take it for granted that all our ethical pronouncements are based on such a consideration. To put it in here and there makes it appear that some of our decisions or rules may be contrary to public policy, which is unwise. Moreover we are legislating for ourselves and not asking for external endorsement, by legislation or otherwise.

Medical Ethics before 1902

This idea of self-regulation may be another of the reasons for the increasing popularity of the Hippocratic Oath in the last two centuries. Alone amongst the ancient codes mentioned in interwar accounts of the history of medicine (such as the Babylonian Code of Hammurabi), the Hippocratic Oath is fundamentally a self-regulatory document. It is the ancient justification par excellence of the idea of professional self determination in modern society. Yet as Jones noted in 1924, it is the undertaking of members of a guild or union.

The growth of collegiate organisation in early modern Europe, most marked in Italy, and imitated in the formation of the Royal College of Physicians of London, and the later Royal Colleges (some developing out of the guild system) provided the nucleus or seed pattern of later professional organisations. The RCP was inward looking, ceremonial, selective, honorific, it had powers to limit the activities of other healers and traders in medicine, and was set up purely and simply to defend its own interests on a basic assumption that this would protect “credulous people”. What was more the behaviour of members of the College was carefully regulated so as to reduce squabbles and conflicts and raise the status of the group as a whole.

Percival’s medical ethics pulled together ideas from enlightenment philosophy, and from a small but important sub-genre of the advice literature on duties and conduct, and set them to a completely different purpose; the creation of a harmonious co-operative professional world for the three branches of the “Faculty” of medicine within a new type of institution; the voluntary hospital. This project dovetailed neatly with the drive for medical reform which aimed to created a unified monopoly of medical practitioners. It is thus no surprise to find an active member of the BMA,


14 Memorandum, CEC s/c, 19.1.1937.
Jukes de Styrap, reworking Percival for British doctors in the last quarter of the nineteenth century. Yet, as I have shown the existence of a statutory boundary, and the survival of unregistered practice in all its many forms created a sharply politicised ethics. Thus Percival set out an ideal for behaviour within a professional space that had yet to be firmly delimited. Once this had occurred, de Styrap, building on the ideas of many colleagues, was able to add an aggressively anti-quack component to the code. The profession continued to pursue this aggressively formulated behavioural code and medico-political agenda until the conditions of society as a whole, the therapeutic capacities of the profession and security in practice consequent on the growth of state medicine all reduced the need to defend the profession in this way. Quite new challenges were to come.

Medical Ethics after 1939

It is clear that in the interwar period the BMA was far more alert to public opinion, and anxious to court it than it had been in the Edwardian era. This trend to negotiate suitable conduct by reference to lay opinion became much more marked in the years following the Second World War. There has been an obvious historical trend toward the use of formal philosophical ethics, and a specific set of legal and sociological critiques to modify medical conduct. Thus a set of rules devised 'by the profession, for the profession' has been transformed into a complex adjudication with reference to ethical concepts of a more formal kind, culminating in the emergence of practitioners of medical ethics itself, many of them not doctors. It is no longer left to the profession to decide what constitutes appropriate medical behaviour. Most professions now find themselves in this position, and recent events in Bristol make it much more likely that professional self-regulation will be modulated by the introduction of more lay supervision. But the emergence of powerful biotechnologies, many of them either primarily medical, or with important medical applications, has also taken the ethical gaze off what one recent commentator termed the "microethics" of everyday encounters.

So can the model of a boundary adjudication of right and wrong behaviour still be applied? In some senses it can: the profession still needs to maintain the trust and sanction of society and unethical behaviours are still those that are seen to undermine this position. These behaviours are now seen

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17 Metcalfe, David, 'Doctors and patients should be fellow travellers', Br. med. J., 1998, 316: 1893. Even here, the locus of this "microethics" was doctor-patient communication.
to involve the breach of rights, the inequitable use of resources, or lack of respect for personal autonomy. Only the principles of confidentiality, and what is now called “beneficence” can be seen to have clear precedents in pre-war medical ethics. But there are other important differences. For one thing this canon and discourse of ethics is now constructed in collaboration with lay people. For another, the boundaries of the profession itself are breaking down with the advent of nurse practitioners for instance, and the rise in status of unorthodox medicine. The doctor is no longer seen as a paternalistic solely responsible figure, but a member of a team. Yet medical ethics still marks doctors out as having particular responsibilities, and as having a particular role. This new model of medical ethics is one generated by a society quite different to that of Edwardian or interwar Britain.

Thus the resurgence in interest in medical oaths and the Hippocratic ideal since the Second World War is particularly striking. Not only was the Declaration of Geneva a reworking of it, more recently the BMA Medical Ethics Committee has been asked to re-write the Oath again for the WMA.18 This can be seen to embody the tension between the need for timeless core values and the need for up-to-date ethical guidance in the context of rapid social and technological change.

“Honour and Interests”

Robert Nye has written beautifully of the influence of generic codes of honour on medical déontologie in late nineteenth and twentieth century France.19 It is also clear that in Germany the notion of honour was central to medical ethics and conduct jurisdiction.20 Given the prevalence of associations, clubs and societies connected to professions and universities in nineteenth century America it would be surprising to find that notions of solidarity and honour were not also important there.

Nye describes the “male codes of honour, cobbled together from elements of the tradition of aristocratic chivalry, and from the rituals and practices of bourgeois professional sociability that once informed the day-to-day medical ethics of French physicians”. These notions, and the cultural form of the cercle, creating exclusive new bourgeois groupings and “juries of honour” were used to settle differences and underpinned a culture of conduct adjudication which stressed the power and

20 Holger Maehle has presented preliminary research findings in this area at a Wellcome Regional Symposium “From medical ethics to bioethics: philosophical and historical perspectives” at the University of Durham, September 1998.
autonomy of the individual doctor. Nye’s work draws out useful parallels with word ‘honour’ in the BMA’s founding aims and their reliance on local and central “courts of honour” to decide ethical questions.

Nye has also been at pains to point up what he sees as the naïveté of ethicists’ accounts of the history of ethics, which have tended to ignore the cultural and social roots of earlier ethical discourses. This kind of history of ethics, that surveys only the high ground of legally and philosophically constructed key events, codes and deliberations, can be set against the ‘other’ history of medical ethics, the sociological critique, or “revisionist school”. This has been very strong on identifying the way in which medical ethics served the interests of doctors, without apparently pausing to reflect that it would be a strange professional ethos indeed that actually undermined the interests of the group concerned. In fact Percival was quite candid on this point, noting that, “the profession of medicine cannot be supported except as a lucrative one.”

It seems more sensible to assume that a profession’s code of conduct suited its wider purposes, and transfer the focus of the analysis and critique to other aspects of the subject.

In this thesis I have tried to evoke as richly as possible the ideas and forms of early twentieth century British medical ethics and to show that whilst medical ethics served a clear social function, (indeed a social function which can be traced in all deliberations and adjudications bearing the label,) it also reflected deeply held beliefs about who these doctors thought they were. What is also clear is that for all its moral content, more often revealed in the breach than in the observance, professional ethics based on group honour could have a negative impact not only on the laity, but on the profession itself.

By honour, it appears the BMA meant independence and status, as well as a sense of personal moral agency and self-responsibility. Yet as we have seen, this sense of honour led the Association to several of its most embarrassing moments. The issues on which the Association took up its most extreme stances were contract practice (where the honour of the profession was insulted by employment by workmens’ committees) and secrecy (where the legal profession overrode deeply felt moral obligations to protect patients’ reputations). On both these issues feelings ran high enough for generic notions of right and wrong to be overridden. In the worst case, the boycott of the Coventry Provident Dispensary, honour was used as a justification for behaviour that was to dishonour the profession deeply. Yet there is no evidence that the Association felt the Coventry men had done anything wrong. This inability to see any wrong doing, except in actions that

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21 Percival, Medical Ethics, 1803, II.xv
reflected poorly on the group or damaged its power, status or interests, is perhaps the single greatest weakness of the medical ethical work done by the Association. Thomas Percival, in his comments on duelling, provided an ample critique of honour as a guide to behaviour, identifying all that was, to modern eyes, worst about medical ethics before 1939.

in principle, it is distinct from virtue, and as a practical rule, it extends only certain formalities and decorums, of little importance in the transactions of life, and which are spontaneously observed by those who are actuated with the true sense of propriety and rectitude. Genuine honour, in its full extent, may be defined as a quick perception and strong feeling of moral obligation, in conjunction with an acute sensibility to shame, reproach or infamy. ... The former always *aids and strengthens virtue*, the latter may occasionally *imitate her actions*, when fashion happily countenances, or high example prompts to rectitude. But being connected, for the most part, with a jealous pride and a capricious irritability, it will be more shocked with the imputation than with the commission of what is wrong. And thus it will constitute that spurious honour, which by a perversion of the laws of association, puts evil for good and good for evil, and under the sanction of a name, perpetrates crimes without remorse and even without ignominy.\(^{22}\)

\(^{22}\) *ibid.*, IV.xiv.
Appendix A: Biographies

Introductory comments

These biographies have been produced largely from BMJ and Lancet obituaries, and the Medical Directory with some use of the Dictionary of National Biography, and other published works. Although there were many actors for whom it has been impossible to ascertain birth dates accurately, vital dates appear, as far as they are known, along with qualifications, and a brief statement of their role in medical ethics, or the BMA at the head of each biography. A list of all sources used to compile each biography is given at the end of each, and I have only provided footnotes for particular items of information gleaned from less routine sources.

More material is available for some figures than is really necessary for the purposes of this thesis, whilst there are others about whom it would be preferable to know much more. This has particularly been the case for actors who died during, or after the 1960s, since when medical journals, including the BMJ, drastically decreased the prominence and length of their obituary notices. (Medical historians of the future will find biographical research extremely difficult to conduct.) Even during the comparatively informative earlier years of the century, obituaries were often unforthcoming on their subjects' social background, place of origin, and schooling. In some cases details of medical practice have been very difficult to ascertain, especially where no appointments were mentioned. Within these constraints I have tried to provide biographies of a length that reflects each actor's importance in the thesis, rather than their prominence in medical politics and medical practice more generally.

If these obituaries are read together, it is clear that the central events of the early twentieth century for the BMA were the 1902 constitution, the Insurance Crisis of 1911 - 12, the organisation of medical manpower during the Great War, the Association's role in Panel politics and Hospital policy, and Planning during the Second World War. The Insurance crisis was particularly traumatic. However, some notes of caution must be sounded. There is a marked tendency in these obituaries for different men to be credited with "a leading" or important role in many of these key areas, and it seems clear that an account of the Association's history is being rehearsed in them, as well as of the dead man's part in it. This may be due in part to the role of Alfred Cox as a memorialist, both in obituary columns and in his autobiography.
Anderson, George Cranston (1879 – 1944)
MB ChB MD LLD FRCP CBE
Deputy Medical Secretary of the BMA 1919 - 1932
Medical Secretary, later Secretary, of the BMA 1932 - 1944

George Anderson was the anonymous author of a great many of the documents examined in the course of this research, since he was secretary to the CEC between 1919 – 1932. The son of a liberal Scottish minister from Jedburgh, he was educated at Edinburgh University, where he was a noted athlete, and qualified in 1904. His early career was spent as a General Practitioner in Methil, Fife, where he also held the post of Medical Superintendent at Wemyss Memorial Hospital. He was active in the Fife Branch of the BMA, becoming its Hon. Secretary in 1911, and serving on the Association’s Scottish Committee and Local Medical War Committee. In the Great War he served three years in Egypt and Palestine.

He joined the central BMA staff in 1919 as a Deputy Medical Secretary and in this capacity worked as the secretary to a number of key committees. These included the CEC, the Hospitals Committee and the Insurance Acts Committee. He was also active in organising the National Ophthalmic Treatment Board, which became the National Eye Service in 1929. When appointed Medical Secretary, “many felt ... he could never fill the place occupied by Cox [but] he found his way into the affection and confidence of the rank and file as assuredly as did his predecessor”. Anderson was Medical Secretary of the Association from 1932 until his death of coronary heart disease and heart failure in 1944. Many of his colleagues hinted strongly that overwork was an important factor in his early death (a conclusion supported by an incidental comment in the archive materials.1)

As Medical Secretary Anderson was heavily involved closely in the setting up of the National Register of Medical Auxiliaries “after difficult negotiations” in 1933, and was a member of the Board of Registration. Although all obituarists agreed on the personal qualities that made him an excellent link with local honorary officials and ordinary medical men, little else of his work is mentioned until the Second World War. This “brought a period of strain comparable only with that experienced by members of the Government and... the fighting forces”, as the BMA once again voluntarily took on the organisation of medical manpower. Despite this workload, Anderson had grasped the importance of participating in planning for medical services after the War, and had proposed the idea for the Medical Planning Commission, and had argued strongly for “Evolution not Revolution” at the ARM of 1943.

This constructive attitude is probably the reason for the Minister of Health’s comment that “I fear we have lost man whose services at this time would be invaluable”. Lord Moran thought that “the loss of a man like Anderson ... just now ... is nearly irreparable ... he knew what the average doctor was thinking ... [but] ...could see beyond the interest of the members of the Association what was good for the country as a whole”.

1 letter to Anderson from Macdonald, 2.12.1937, in CMAC SA BMA D98
Anderson was succeeded by Charles Hill, who proved to be something of a match for the pugnacious Nye Bevan, and it is tempting to speculate whether Anderson's survival would have influenced the final form of the NHS. Honigsbaum, almost certainly drawing on Hill's autobiography, stated that Anderson "lacked the ability to make decisions". Anderson's work for the CEC certainly shows a marked tendency, whilst enunciating core values and ideas clearly, to see all sides of an argument. His memorialists mentioned not only his "cogent ... but courteous" rebuttals of criticism of the Association, but also his "sense of humour and something of a philosophical detachment ... it was refreshing to catch the twinkle in his eye when a committee - or some members of it - were taking themselves too seriously". It appears consistently in the obituaries that he was a kind, courteous, humorous, tactful but straightforward man. Preceded in office by James Smith Whittaker (q.v.) and Alfred Cox (q.v.) - two single-minded medical unionists - and succeeded by the flamboyant and justly famous Charles Hill, it seems likely that Anderson is destined to remain one of the forgotten figures in twentieth century medical politics.


Bateman, Alfred George (c.1856 – 1919)
LSA MB CM
Secretary of the MDU 1888 – 1919
CEC member 1902 - 1919

Bateman was a leading member of the MDU, serving as its chief executive officer between 1888 and his death in 1919. He also sat on the CEC for the last 17 of those years. Although his obituarists, and Forbes, all mention his enormous appetite for this work, no details of his medical career can be ascertained save that he was trained at St Bartholomew's Hospital and the University of Aberdeen, seemingly in that order, qualifying LSA in 1879 and MB CM in 1881. His address was always given as Queen Anne Street, London, and thus the assumption must be that he was a West End general practitioner, at least initially.

Bateman made a great name for himself as a kind of detective and prosecutor of unqualified practitioners and was responsible for the vast majority of the MDU's cases of this type before the GMC. As the man responsible for all MDU business between Council meetings he gained a reputation for sound and well-considered advice to members. He achieved all this whilst struggling with severe asthma.

His obituary describes him in perhaps self-consciously Doyleian terms: "Probably no one was better acquainted with the customs, convention, and traditions of medical practice, or with the rights, liberties, privileges, duties and ethical obligations of medical men in their relations with each other and with the public.
... His acquaintance with the few “black sheep” of the profession, with quacks, tricksters and unqualified practitioners generally was indeed extensive and peculiar. He seemed to have an instinct for finding out offenders and a genius for bringing them to justice. He spent months and sometimes even years in watching or tracking suspected persons, but he did not strike or invoke the help of the Courts of Justice until he was in possession of complete legal proof.” W E Hempson, the MDU and BMA solicitor commented that in his cases “success was assured”.


Biggs, Moses George (c.1867 – 1935)
MRCS LSA MD
Chairman of the CEC 1912 - 1919

The very short BMJ obituary of Moses Biggs opened with a slightly defensive statement that he was “for many years identified with the local and central work of the BMA, and all his colleagues held him in the highest regard.” He was also the president of the South-West London Medical Society. Biggs took over the chairmanship of the CEC, of which he had been a member only a few months, when the controversy surrounding the National Insurance Bill forced the incumbent chairman, Lauriston Shaw, to resign mid-session. He went on to hold the position until 1919.

Nothing is known of his background. He qualified MRCS LSA from University College London at a date given conflictingly in the sources, but probably the late 1880s, and went on to achieve a Durham MD in 1891. He worked for some 5 years as a house surgeon in Salisbury Infirmary, where he wrote a small book, Hints to young nurses. He moved to Battersea around the turn of the century and settled into general practice along with an appointment as surgeon to Battersea Dispensary. In this capacity he was soon to be involved in a controversial Coroner’s hearing instituted by the vigorous Mr Troutbeck after one of his patients died following an operation for brain tumour by Victor Horsley.

Cox, Alfred (1866 - 1954)
MB OBE
Medical Secretary of the BMA 1912 – 1932

Cox, uniquely among this list of actors, wrote an autobiography, Among the doctors, which appeared in 1950. This is an apparently frank book, its omissions being obvious, and thus his background, education, political beliefs and much of his character can be ascertained. He also wrote well about his friends and colleagues, and was a frequent contributor to BMJ obituaries. Cox was born into a large working class family in Darlington, and his father worked as an engineer and foreman. He was encouraged to become a teacher but found the work uncongenial, and after an abortive spell as an insurance clerk, became dispenser and assistant to a Doctor in Carlisle in 1884. This fellow ran a flagrant medical business along lines that the BMA and GMC were later to disapprove, and the “unqualified assistant” route into practice was closed in 1899. Cox himself was in danger of becoming stranded like countless others, since his master worked him so hard that he had no chance to study for his matriculation. He found another, more sympathetic post in Stockton-on-Tees and was eventually able to enrol at the Medical School in Newcastle-on-Tyne. He qualified as plain MB in 1891 having worked as an assistant throughout his student years.

On setting up practice in Gateshead in the mid 1890s, he quickly interested himself in the problems posed by contract practice, disunity and in-fighting amongst his colleagues, as well as local politics. A Liberal, who also managed a friendship with Keir Hardy (a guest on a number of occasions), as well as local political opponents, Cox’s mind appears to have turned to the application of the collective union ideal to the problems of medical politics. He set up a thriving medical society, which became the Gateshead Division of the BMA in 1902, instigated a reorganisation of contract practice in Gateshead, and contributed to contract practice campaigns in the Durham coalfields. Most importantly, as a representative of his branch of the BMA, he was responsible for the resolution of the 1900 meeting of the Manchester Medical Guild that set the reform of the BMA in train.

Cox was, not surprisingly, offered the post of Organising (later Medical) Secretary to the new BMA in 1902, but stood aside for Smith Whittaker (q.v.), waiting until 1908 to move to London as his Deputy. When Whittaker left the BMA Cox, along with a new Deputy, James Neal, were left with the task of nursing the Association after its acrimonious civil war over the Insurance Act. All his memorialists agree that he was instrumental in mending innumerable friendships and re-establishing unity. Cox himself later stated that in his view, the Conservative “die-hard” elements (among them James Barr - “a tearing demagogue”) had ill-served the Association and treated several of its “faithful servants” (many of them appearing in this section) extremely badly.

With the outbreak of War, the Association took on itself the task of organising medical manpower to balance civilian and military needs, a huge task for which Cox was awarded the OBE. After the War he busied
himself with a survey of medical practice in Britain that formed the foundations of the Association's proposed “General Medical Service for the Nation” (1932), and managed to prevent a damaging feud between GP’s and Medical Officers of Health. He was also instrumental in the affiliation of the Canadian Medical Association with the BMA, the merger of medical associations in South Africa, and in the Association Professionelle Internationale des Médecins, the forerunner of the World Medical Association. In retirement he took on the secretaryship of the British Health Resorts Association.

His obituarists all agreed on his straightforwardness, skill in befriending those he worked with, and above all, his single minded commitment to the Association and the ideals it stood for. Cox appears never to have lost his combination of commitment to the ideal of medical collective power with political and personal tolerance. His autobiography recounts fondly, for instance, a meeting at which he was recognised as an opponent of equal measure and common kind by miners in South Wales. The final assessment of his *Lancet* obituary seems an accurate and fair picture of him; “a man of many sympathies and interests, ... the friend of all and the enemy of none”.


Dain, H Guy (c.1871 - 1966)
MRCS LRCP MB (MD LLD FRCS)
Direct Representative GMC 1934 - 1961
At times Chair of Insurance Acts Committee, Representative Meetings and Council.

Guy Dain was a Birmingham man all his life. He was born and educated there, and qualified MRCS LRCP from the Josiah Mason’s College (to which in 1892 the medical department of Queen’s College Birmingham was transferred) and passed the London MB the following year. He settled down to general practice in Selly Oak shortly afterwards. He became involved in the BMA after 1911, and was initially mainly involved in Panel politics, serving on the Insurance Acts Committee between 1917 and 1936, taking over the Chair from (Sir) Henry Brackenbury in 1924. He also chaired the Panel Conference between 1919 and 1924.

He went on to become a very long serving member of Council (resigning in 1960), he chaired the Representative Body between 1937 and 1943, and then became Chair of Council, and was thus in the forefront of the prolonged negotiations over the NHS. Even before this he was a successful BMA-sponsored Direct Representative on the GMC from 1934 - 1961. He was said to be a “quiet logical speaker” and “tireless in negotiation” but capable of stirring an audience. Charles Hill said that “He looked what he was; a competent and conscientious family doctor from Birmingham”.

Dawson, Bertrand (Lord Dawson of Penn) (1864 - 1945)
BSc MD MRCS FRCP KCVO
Royal Physician and Medical politician

Lord Dawson was a highly important figure in the medical world of the interwar years, and the following is simply a brief sketch of his life. The son of a London architect, Dawson was educated St Paul’s School and University College, London. He received his basic medical qualifications in 1888 - 90 and for the next decade and a half lived the precarious life of a lecturer and hospital junior. By 1903 he was an FRCP, and was appointed Physician to the London Hospital in 1906. Shortly afterwards he became a Physician Extraordinary to King Edward VII.

In 1918 he made a well-timed speech to the West London Medico-chirurgical Society, on the role of the profession in promoting the national health. This along with his Court prominence, resulted in his appointment to the famous committee that produced the “Dawson Report” (Interim Report on the Future Provision of Medical And Allied Services) in 1920. Despite the ignominious fate of this Report in the post war slump and Government retrenchment, from this point on his rise was steady. He was made a Baron in 1920, and thereafter he was a champion of teaching hospitals and the medical profession generally in the Lords. He also supported birth-control, divorce law reform, and the reform of the prayer book, but opposed voluntary euthanasia, encroachments on medical secrecy, and the registration of osteopaths generally and of Herbert Barker in particular.

In the 1930’s, in addition to his role as Royal Physician, Dawson was ‘president of everything’, starting with the RSM in 1928 - 30, the BMA in 1932, the RCP 1931 - 38, as well as serving on the Privy Council after 1929. During the Second World War he was involved in organising the Emergency Medical Service and also in the BMA and Ministry of Health’s Medical Planning Commission. Dawson was a medical statesman who whilst supporting some progressive reform, particularly in the RCP, was a staunch defender of the moral and clinical independence of doctors. He also had a gift for a kind of pompous eloquence, the best known example being his bulletin on the illness of George V: “The King’s life is moving peacefully towards its close”.

Forbes, Robert (c.1890 – 1975)
MB ChB
Deputy Medical Secretary BMA 1932 – 1935, later chair of the CEC
Secretary of the MDU 1935 - 1959

Robert Forbes trained in medicine in Glasgow, qualifying in 1915. He worked as a House Surgeon to the Royal Victoria Infirmary, Glasgow, before joining the RAMC for the reminder of the War. On being decommissioned he moved to Gateshead, and practised as a GP, as well as holding an honorary consulting surgeon post at Gateshead Childrens' Hospital. He later became involved in BMA work, and represented his Division from 1929 at ARM’s. When Anderson was promoted to Medical Secretary, Forbes filled one of the vacancies as Deputy Medical Secretary, and appears to have worked as the CEC’s secretary during this time.

With the death of James Neal in 1935, Forbes followed the pattern set by his predecessor and moved to become the Secretary of the MDU - its chief executive officer - until 1959. During this time he also sat on the CEC, and was its chairman in the mid-1950s. He was a member of the Medico-legal Society and a Justice of the Peace. In his retirement Forbes moved to Devon, and built up a thriving practice as a locum.


Fothergill, Ernest Rowland (1864 – 1942)
MB BS
Member of BMA Council 1904, and 1914 – 1939.

In the minutes of Committees, Council and Annual Meetings of the BMA certain names appear so often that they attract attention. One such name, usually given as the proposer of a problematic objection to a proposed policy, was “E R Fothergill, Brighton Division”. He was responsible for a very large number of the "wrecking resolutions" faced by the CEC over the period studied. He was, it seems, the BMA’s busy-body for nearly 30 years.

Born in Ryde, on the Isle of Wight, Fothergill was educated at Malvern College and graduated in medicine from Durham aged 29. He worked for some time as Clinical Assistant at Durham County Asylum, and then moved to Cornwall, working as a general practitioner. He moved to Wimbledon around the turn of the century, where he was the Representative for Wandsworth Division. Cox stated that he found London practice uncongenial, and in 1911 “he took a large house in Hove, where, with the help of his wife ... he received resident patients. This left him with a good deal of spare time which he devoted mainly to keeping the staff of the Association under close observation, and well aware of it.” Incidentally Fothergill published
in the *BMJ* on “Exhaustion and Drug Addiction”:\(^2\) a rather tantalising insight perhaps into his clientele in Hove. He also worked as an examiner for the British Dominions and other insurance companies, and (here there is some confusion) possibly as a Panel GP. He was certainly involved in local Panel and Insurance Committees for many years.

Cox described him as ‘one of the best known BMA ‘characters’ ... a tall, well set up man of rather austere appearance, not a particularly good mixer and a pronounced individualist who was at the same time a most devoted worker for co-operation amongst doctors. ... He wasn’t exactly popular”. His obituary described his as “often a thorn in the side of chairmen and others”, introducing a “sheaf of amendments” in a “brusque staccato”. This obituarist tried to explain Fothergill’s behaviour as stemming from an idea that unless social and economic advancement went hand in hand with scientific discovery, medicine could not progress. Yet this appears to have translated into an extremely conservative defence of individual private practice and bullish determination to get the best for doctors in their co-operation with the State. In this role, Fothergill actually had some impact on BMA policy. He was credited with the vital development of the Association’s Insurance Acts Committee as the bargaining body for all Panel practitioners, a role which helped increase the Associations relevance, membership and unity in the interwar years. (It had seemed possible that a rival, ad-hoc body might fill this role.) He achieved this by arranging a meeting of Panel Practitioners in Brighton Pavilion at the time of the BMA’s Brighton ARM in 1913.

Fothergill also had influence in the formulation of the BMA’s hospital policy and sat on the Hospital Committee between 1921 and 1933. Here his central concern was to prevent “visiting medical staffs be[ing] exploited” as pay beds and private wings were introduced. His obituarist noted that “he was probably the most assiduous letter writer the Association ever had, and some of his letters were extremely pointed” and that his correspondence formed a record of the medical politics of a generation. Sadly I have found no trace of any such sheaf of letters in the archives, a pity, since “these frequent essays in penmanship were undertaken by a man who had no real gift for writing. He was inclined to call literary form mere “verbiage” - a word he often used and always with scorn”.

**Sources:** *Br. med. J.*, 1942, i: 166; *Medical Directory*; Cox, *Among the doctors.*

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\(^2\) *Br. med. J.*, 1927 i: 1103.
Harman, Nathaniel Bishop (1869 - 1945)
MB BS MD FRCP
Treasurer of the BMA 1925 - 1939
Direct Representative on the GMC 1929 - 1945

Nathaniel Bishop Harman, grandfather of the now more famous Harriet, was an eminent “eye man” and prominent Unitarian, who also served for many years as the BMA’s treasurer. In that capacity he attended far more CEC meetings than any other ex-officio member, making him in effect a “long serving” albeit unelected member. Educated at the City of London School, and “after a few years in business” went up to Cambridge, as foundation Scholar at St John’s, and completed his medical training at the Middlesex Hospital. Highly able, he qualified MB FRCS in 1898, and then served as a Civil Surgeon in the Field Force during the Boer War. He went on to specialise in ophthalmology, and took a great interest in the prevention of blindness (particularly that caused by gonorrhoea) and the education of children with defective sight. The policies he proposed; the notification of ophthalmia neonatorum, and the promotion of sight-saving classes and special education for the severely myopic won him much praise in the 1920s and 1930s. He was Lecturer and later Dean of West London Postgraduate College, Ophthalmic Surgeon to the West London Hospital and the Belgrave Hospital for Children, and consultant to the National Institute for the Blind.

Harman was a staunch opponent of sight testing opticians, and had a great influence on the 1920 - 22 Departmental Committee on Causes and Prevention of Blindness. He was also closely involved in the National Ophthalmic Treatment Board, as well as serving for many years on the BMA’s Ophthalmic and Hospitals Committees. On the latter committee he supported the payment of hospital staffs.

Harman was elected three times as the BMA’s Treasurer, and three times as a BMA sponsored Direct Representative on the GMC. In 1937 - 38 he was President of the General Assembly of Unitarian and Free Christian Churches. Described as having a “reflective habit of mind ... skill in the simple illustrative exposition of what he saw as the truth”, he was also said to be “a ready - almost a too fluent speaker ... skilful in the use of kindly satire [to the point that] sometimes his eagerness in debate and his enjoyment of subtle juxtapositions led him into impulsive judgements and argumentative fallacies”

Sources: Br. med. J., 1945 i: 888; Cox, Among the doctors.
Hawthorne, Charles Oliver (1858 - 1949)
MB CM MD FRFPS FRCP
Long Serving member of BMA Council and CEC
Chairman of the CEC 1933 - 1935

Hawthorne was apparently something of an enigma even to those who worked with him, and his real age came as a surprise to BMJ editorial staff when his obituary was first prepared in the 1930s. Hawthorne had trained in Glasgow, earning the Burton Memorial Prize for most distinguished graduate when he qualified MB CM in 1884. He worked as assistant to the professor of the practice of medicine in Glasgow, and as clinical tutor on the wards of Sir William Gairdner at the Western Infirmary for 10 years, before becoming Assistant Physician there. He lectured in Materia Medica at Queen Margaret's College, Glasgow, and was an examiner to all the Scottish medical schools. At this time he published several works on medical education, materia medica and medical jurisprudence. Gairdner was also interested in medical education, character and conduct, and it is possible that this was where Hawthorne first became involved in conduct and discipline.

For reasons that are not at all clear, Hawthorne moved down to London where he became a well-known Harley Street practitioner. He was also Lecturer in Medicine at the Medical Graduate College and Polyclinic between 1909 - 14, Physician to the Hampstead and North-West Hospital (after the dispute outlined on pp. 114 - 8 had been settled), the Central London Ophthalmic Hospital, and the Royal Waterloo Hospital for Women and Children. Hawthorne was evidently popular, according to Cox, "few men in BMA circles have inspired more affection and respect" and he had been "a most successful Chairman" of the CEC. His obituarist described him as "the Nestor of the British Medical Association Council, but also the Rupert of debate ... an effective speaker with a fine memory which enabled him at the right moment to produce the right quotation or telling anecdote." His pronouncements, whether written or reported, have always struck me as rather long-winded and, despite their great style and humour, not a little vague.

Sources: Br. med. J., 1949, ii: 986, 1054, 1118; Cox, Among the doctors.

MB BS FRCS FRS
President of the MDU, and BMA, Chair of Representative Meetings, BMA and Direct Representative GMC.

Horsley is now best remembered as a pioneer in neurosurgery and physiology, and was in his own lifetime a widely respected clinician and medical scientist, but was also a keen medical-polician. Aside from serving as President of the MDU, as an early Direct Representative on the GMC (before the BMA scheme was initiated) he was "one of the leaders of the BMA". Specifically, he took an active role in steering and drafting the new
BMA constitution, and was the first Chair of Representative Meetings. He was “always on the side of reform inside the profession; and was incessantly befriending his less fortunate brethren”.

Horsley was the second of seven children, brought up in Kent, educated at Cranbrook Grammar School, and at University College London. Between 1884 and 1890 he was Professor-superintendent of the Brown Institution, a centre for veterinary science and physiology, where he did work on thyroid, protective treatment against rabies, and localised functions of the brain, working extensively on monkeys. In 1885 he became an Assistant Surgeon at UCH, and in 1886 was elected to the Royal Society, the professorial chair in pathology at UCL and as a consultant to Queen’s Square Hospital. His pioneering brain surgery was undertaken in the late 1880s, being for instance the first to successfully remove a tumour of the spinal column in 1887. He was knighted in 1902. His last involvement in BMA politics was a mass meeting in December 1912 at which he was shouted down by an angry mob of doctors. He died of heatstroke whilst serving in Mesopotamia.

Source: DNB, Cox, Among the doctors.

Kinsey, Robert (qualified 1865, retired 1910)
MRCS LSA JP
Chair of CEC 1905 - 1909

It would be good to know more about the man who drafted the document outlining the duties of members to the Association in the wake of the Hampstead Case (see pp. 114 - 8), but no obituary can be found, and his Directory entries are very terse. Kinsey undertook his medical training at St. Bartholomew’s Hospital and qualified in 1865. He was consultant surgeon to Bedford County Hospital and to HM Prison, Bedford, and was also a Justice of the Peace.

Source: Medical Directory

Langdon-Down, Reginald Langdon (1866 - 1955)
MA MB BC MRCP(L)
Member of the CEC for four decades, Chairman 1919 - 1926

Langdon-Down’s father, J L H Langdon-Down, himself the son of a shopkeeper, founded and ran, with the help of his wife, a highly successful nursing home in Teddington for the mentally defective and disturbed members of well-to-do families. On his death in 1896 ‘Normansfield’ was taken over and run by Reginald
and his brother Percival. Reginald Langdon-Down continued in charge of the home after his brother's death in 1925 until it was taken over by the NHS in 1948.

Both brothers had gone up to Trinity College Cambridge from Harrow School, and completed their medical training at the London Hospital. Reginald continued the family interest working as Physician to the National Association for the Welfare of the Feeble-minded, as was a Fellow of the Medical Psychological Association. Besides this and running 'Normansfield', he practised privately in the Richmond/Twickenham area and later developed a West End consulting practice with an interest in children and child development.

This seems to have left him with a great deal of time to devote to the BMA, although he never held any of the higher offices in the Association. He was a Division Representative at thirty ARM’s, and a member of the Council between 1917 and 1937. He was best remembered, by the time of his death, for his long service on the CEC, and for his chairmanship of the Psychoanalysis Committee 1926 - 1929. He was described as a sympathetic and patient man, capable of understanding widely divergent points of view and well suited to resolving matters of heated controversy. The reasons for his remaining a relatively lowly Association man can only be guessed at, and may have been personal. My overall impression of him is a liberal, intelligent and kindly man, with a great deal of time on his hands, but little ambition.

Sources: *Br. med. J.*, 1955, i: 1433; *Medical Directory*.

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**Lyndon, Arnold** (c.1861 - 1946)

LSA MRCS MB MD OBE

Chairman of the CEC 1926 - 33

After a “highly successful” student career Arnold Lyndon worked as a house surgeon in general and ophthalmic surgery at his teaching hospital St. Bartholomew’s, and also at the Royal Orthopaedic Hospital. Rather than pursue a career as a metropolitan surgeon, he settled in Hindhede on the Surrey/Hampshire border and acquired “a high reputation as a general practitioner” with an extensive surgical practice. During the Great War Lyndon organised the Brayshott Auxiliary Hospital, and was awarded the OBE for this work.

Lyndon was an active member of the MDU, serving for many years on its Council, and on the Standing Joint Committee of the MDU and Medical Protection Society. He was also active in the BMA, representing his Division between 1920 and 1931, and serving on the Council between 1922 and 1935. He was said to have shown “exceptional zeal and ability” as the Chairman of the CEC, and would have taken a higher role in the BMA but for ill health. N E Waterfield wrote of him: “he seldom had any difficulty in bringing a meeting round to his point of view. No slipshod or ambiguous resolutions ever got past him”
Sources: Br. med. J., 1946, ii: 797; Medical Directory.

Maclean. (Sir) Ewan John (1865 - 1953)
MB CM MD FRCP FRS (Edin.) JP
Chairman of the CEC 1909 - 10

Although Maclean served such a short time as Chairman of the CEC, his career was interesting and eventful. This "polite and fastidious", and evidently religious bachelor was born in Carmarthen in South Wales, and educated there, and at Edinburgh University. His brother Donald went on to become a prominent Liberal politician. He specialised in Obstetrics and Gynaecology, although interestingly without a surgical qualification, and was the Senior Gynaecologist at Cardiff Infirmary. He went on to become Professor of Obstetrics and Gynaecology when the Welsh National School of Medicine was created. He also took an active role in the formation of the Royal College of Obstetricians and Gynaecologists, and was its first President.

Maclean became involved in the BMA at local and national level during the early years of the century. It fell to him, as Chair of Representative Meetings to chair the stormy special meetings during the Insurance Crisis, including the famous meeting attended by Lloyd George. His liberal connections made his position difficult and he felt impelled to resign, taking no part in BMA affairs again for over a decade. His rehabilitation was completed by his Presidency of the Association 1928 - 29.

Sources: Br. med. J., 1953, ii: 941; Medical Directory; Cox, Among the doctors.

McCardie. (Sir) Henry Alfred (Mr Justice McCardie) (1869 - 1933)
Noted Barrister and Judge
Counsel for the Coventry Dispensary doctors, Judge at the Coventry Case, and a progressive voice on Divorce and Abortion Law Reform.

Henry McCardie, a liberal lawyer of Irish Protestant stock was born and educated in Birmingham, was an interesting man in his own right, but, by chance played an important role in several of the areas with which this thesis deals. No stranger to controversy, even the manner of his dying - by his own hand after a prolonged bout of 'flu in 1933 - was a cause celebre at the time, and only adds to his fascination in retrospect.

McCardie was a prodigiously hard worker who was made up to the Bench despite his political views, having first built up an enormous practice at the Bar, his chambers being known as "the lighthouse" in recognition of the midnight oil burnt there. He refused Joseph Chamberlain's offer of a safe seat in Parliament (although I cannot discover exactly when) and his appointment in 1916 "placed apopn the Bench a man who had proved to
be the most outspoken critic of the system he was placed there to administer". He believed that imprisonment made people worse not better, and felt divorce laws were obsolete and a travesty of justice. Noted for his kindly treatment of witnesses he was said always to have placed "humanity" above the Law. His judgements were to become widely respected for their clarity and erudition. A friend of the conservative F E Smith, (another self-made man, who became Lord Chancellor), McCardie was a lonely man, and, I would conjecture, became deeply depressed when illness prevented him from working in the winter of 1933.


Neal, James (c.1866 - 1935)
MRCS LRCP
Member of, and secretary to, the CEC 1910 - 1935
Secretary of the MDU 1919 - 1935

Educated at Epsom College, and at Queen’s College, Birmingham, Neal passed his conjoint examination in 1891. He set up in “successful” general practice in Birmingham, where he served a “long apprenticeship in medical politics “initially being involved in the MDU, and becoming an active member of the BMA after 1902. He became a Division Representative, and briefly a member of the CEC, and then in 1912 when Alfred Cox became Medical Secretary, joined the BMA Central Staff as Deputy Medical Secretary. He worked in this capacity for 7 years, including secretaryship of the CEC, increasing “his circle of friends and his sphere of influence and usefulness”. When Alfred Bateman (q.v.) died he was (unanimously) appointed Secretary of the MDU, and like Bateman, was to die in office, in 1935.

During this sixteen year period he was “a great pillar” of the CEC, and also served on the Special Pathology and Pathology Committees 1925 - 1927 and on the Patent Reform committees 1930 - 1932. As Secretary of the MDU he was noted for his “ability, tact and courtesy”. He was “seldom given to lightning decisions, he preferred to master every detail of a case before concluding on the right line of action, and once he had made up his mind it was very difficult to turn him from [it]”. He was also said to be “exceedingly skilful in the art of managing his Council ... nearly always getting them to confirm his point of view”.

Sources: Br. med. J., 1935, i: 448; Cox, Among the doctors.
**Parry, Leonard Arthur** (1870 - 1958)
CEC member 1925 - (1939)
Author on medico-legal topics

Parry was “a very well known general practitioner in Brighton and Hove”, noted for his “engaging manner, quick mind and wide knowledge, especially of anything to do with the forensic side of medicine”. He trained at Guy’s Hospital, and held a resident appointment there before, settling on the South coast, where he continued his surgical work, and developed an interest in paediatrics. He was Surgeon and later consulting surgeon to Royal Alexandra Hospital for Sick Children, and the Hove Cripples Guild, Medical Officer to Barnardo’s Home, Brighton School for Blind Boys, Hove Education Committee and Brighton Grammar School. He also held a wide range of positions in Brighton Division, which he, along “with E R Fothergill and some others, made ... one of the most ‘live’ ... in the Association”.

On the CEC he “had a good deal to do with the reorganisation of the ethical machinery of the Association and with the revision of the rules of procedure governing expulsion cases.” He was a member of the Medico-legal society and wrote a number of books on rather ghoulish subjects, including; *The Risks and Dangers of various occupations and their prevention* (1900), *Some Famous Medical Trials* (1927), *Criminal Abortion* (1932), which carefully avoided ethical and legal questions, and *The History of Torture in England*, (1934).

**Sources:** *Br. med. J.*, 1958, i: 523; *Medical Directory.*

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**Saundby, (Prof) Robert** (1849 – 1918)
MB CM MD FRCP(Lon)
Academic physician, pathologist and medical politician
Founding Chairman of the CEC and author of *Medical Ethics*

Robert Saundby, who was born in London, turned to medicine after a “false start” as a tea planter in India. He was a distinguished medical student at Edinburgh, and two years after graduating, in 1876, was appointed pathologist to the Birmingham General Hospital. He made physician to the hospital in 1885, a post he held until 1912, and was elected FRCP (Lon) in 1887. In 1892, when the medical department of Queen’s College Birmingham moved to Josiah Mason College, he was awarded the Chair of Medicine. He published a number of books and innumerable papers, including a book on the diseases of the digestive tract, and another, more successful on the diseases of the kidneys and urinary system.

Saundby was not simply an academic, he was an active BMA member, involved in the Midland Medical Society, and helped build up a library at the Birmingham Medical Institution. Birmingham was at that time a hotbed of medico-political activity and he was the first treasurer of the Midlands branch of the MDU, the
Union's strongest branch and main focus in the late 1880s. He served on the central Council of the MDU from 1887 – 1900. He was also active in the BMA and served on the CEC’s predecessor committee, the General Practice and Ethical Committee. He drew on this experience to produce his first edition of Medical Ethics, arguably the most influential text on the subject written in early twentieth century Britain, and certainly one of the most carefully and robustly written. His BMJ obituary described it as “a valuable volume in its day [which] may be said to have laid the foundation for the medico-ethical work of the Association.”

Despite this apparently excellent reformist medico-political pedigree, Saundby was not a member of the reforming Constitution Committee of 1900 – 1901, despite serving on its immediate predecessor, and his chairmanship of the new CEC was brief. An explanation can be found in the fact that he became Professor of Medicine in the new University of Birmingham in 1904 and was the University’s representative on the GMC from 1905 – 1917; an appointment that he said clashed with close involvement in the BMA’s ethical work. But there are also some signs that he was unhappy at the direction the Committee taking, especially on the question of consultation, and he could not be relied upon to support the Association’s line in GMC meetings. Despite this he was elected President of the Association and served the awkward term of 1911 – 12.

Gilbert Barling described Saundby as “handsome [and] intellectual looking ... full of enthusiasm for the scientific side of medicine, and a prodigiously hard worker”. He also commented that “those who knew [him] only slightly will perhaps recall occasional offence arising out temperamental irritability. It would be idle to deny this defect, but it did not represent the real man, and when the moment of irritability was over no one had deeper regret for the incidents than he himself”. He retired from the GMC in 1917 increasingly troubled by heart failure, and died a few months after the confirmation that his son, a pilot on the Western Front, was missing presumed dead.


Shaw, Lauriston Elgie (1859 – 1923)
MB MD MRCS(Eng.) FRCP(Lon)
Chairman of the CEC 1910 – 13

The son of a doctor, Shaw was educated at City of London School and University College London, qualifying in 1881, and became Assistant Physician to Guy’s Hospital relatively swiftly in 1889. He developed a Harley Street practice, and a leading role at Guy’s, becoming Dean in 1893. In 1907 he became Full Physician at Guy’s and was also elected to the Council of the BMA, and to the CEC. He resigned his chairmanship of the
committee mid-session after the Association passed motions of “deep condemnation” of his leading role in breaking the opposition to National Health Insurance.

He was a supporter of the co-operation between State and doctor, although he opposed full-time salaried service, and on principle supported the introduction of Insurance Panel practice. In Jenner Verrall’s words “he knew full well that his support of so unpopular a measure must greatly injure if not destroy his position as a consulting physician. It was not in him to waver. ... There was a grim irony in the fate that brought him, chairman of the CEC, into strong collision with so large a majority of the Profession ... In that frail body, behind that quiet voice and rather pathetic smile, there dwelt a brave and unselfish spirit”.

Sources: Medical Directory; Br. med. J., 1924, i: 40; Cox, Among the doctors.

Waterfield, Noel Everard (c.1877 - 1960)
MB BS LRCP FRCS
Chair CEC 1935 - 1947 (?)
Direct representative on GMC 1945 - 1956.

Waterfield was trained at St. Bartholomew’s and worked for most of his life as a Surgeon and General Practitioner in Surrey. Prior to this he served as a civil surgeon with the British Mediterranean Expeditionary Force and as Medical Inspector of the Government of Sudan. He was an honorary Medical Officer to Horton General Hospital, Medical Referee for the Pearl Assurance Co., and Chairman of Oxfordshire Local Medical and Panel Committee. His obituarist described him as “an old fashioned radical who would not read the Observer after its criticism of Eden” and who “never quite unbent”.


Whittaker, (Sir) James Smith (1866 - 1936)
MRCS LRCP
Medical Secretary of the BMA 1902 - 1912

The BMJ took the unusual step of naming Whittaker’s obituarist at the head of the notice. Alfred Cox, with his excellent BMA credentials took the opportunity of defending and vindicating his old colleague. Smith’s career was notable for two main things; firstly his key role in the creation of the new BMA constitution, and secondly his controversial “defection” to the Insurance Commission at the height of the Insurance Bill crisis.

^ Council, 29.1.1913.
The latter act apparently obscured all memory of the former, and perhaps Cox felt badly about this, since he had, he later said, counselled him to make the move.

Smith Whittaker was a Yorkshireman, educated at Manchester Grammar School and Owen’s College, Manchester University. After passing his conjoint exams in 1891 he went into practice in Great Yarmouth, then “smarting under some of the worst abuses of contract practice” and was a leader in the (failed) medical agitation against the Medical Institute there. An unknown delegate to the 1900 Guilds conference he “produced a great effect on his audience when he spoke” in favour of a new organisation to represent doctors. When the conference decided to back the BMA he became a member of the constitution committee, and was, according to Cox, the “draftsman of Horsley’s principles”. Cox praised his “grasp of principle ... attention to detail ... great attainments as a draughtsman [and] gift of logical persuasion” but noted that “he wasn’t always an easy man to work with”. A widely read man of great political astuteness, he impressed Lloyd George, and when invited to join the Insurance Commission, decided that the profession needed a strong advocate there. This was seen as an act of treachery by many in the Association at the time, whilst David Green has described it as a move to an even more influential position from which he worked to suppress lay-organised medical care. Cox stated in 1950 that Whittaker had “died a misunderstood and a disappointed man”, leaving behind a wife and two sons, both in medical practice.

Appendix B

"The medical pundits": doctors and indirect advertising in the lay press, 1922 - 1927


"Is a practising medical man to be entitled to set out by means of modern publicity - newspapers, magazines, radio broadcast, and the cinema - the easily stated facts of health knowledge and disease prevention; or is the consulting room or surgery to be the sanctum sanctorum of such knowledge?"

"for many years now the attention of the great British public had been focused upon [Sir Dudley Rumbold Blane]. It was Sir Rumbold who, a quarter of a century before, staggered humanity by the declaration that a certain portion of Man's intestine was not only useless, but definitely harmful. Youghurt, and the lactic acid bacillus....and now in addition....he wrote the menus for the famous Railey chain of restaurants: "Come, ladies and gentlemen, let Sir Rumbold Blane MD FRCP help you chose your calories!" Many were the muttered grumbles amongst more legitimate healers that Sir Rumbold should have been scored off the Register years ago: to which the answer manifestly was - what would the Register be without Sir Rumbold?"

This paper will examine a controversy argued out between 1922 and 1927 in the committee rooms of the British Medical Association (BMA) and General Medical Council (GMC) and in the columns of the medical and lay press. It centred on the ethics of doctors signing articles in the lay press on general medical matters, diet and hygiene. This practice was considered by many doctors, including members of the GMC, and officials of the BMA to be a form of "indirect advertising". Others, including those involved in producing such journalism, presented it as a form of health education, a vital part in the effort to improve the fitness of the people. The controversy reveals not only the way in which this journalistic role for doctors ran counter to an ethical code that referred mainly to the world of Victorian and Edwardian private practice. It also shows deep and general tensions between differing 'sorts and conditions' of doctors, their aspirations and models of medical behaviour. Most explicitly it reveals professional and lay criticisms of the GMC and the BMA during the mid 1920's.

One of the protagonists in this controversy was Sir William Arbuthnot Lane, a prominent and wealthy London surgeon, who challenged the rules on advertising laid down by the BMA and GMC. Its most dramatic focus was a case for libel brought by the BMA against The Star newspaper in 1926. The allegedly libellous article commented on a dispute between Lane and the BMA Central Ethical Committee (CEC), and on a widely reported incident involving a photograph of Lane which appeared on 40,000 Lyon's Tea Rooms menu cards. The reaction of the press to the incident and the reaction of the BMA to this wide and critical coverage, and indeed the way in which the BMA were to drop their case against the Star, are among the events that this paper seeks to describe and explain. The libel action generated a great deal of preparatory


2 A. J. Cronin, *The Citadel*, London, Victor Gollancz, 1937, p. 266. The close rhyming of the pseudonym and the career details indicate that this passage was based on Sir William Arbuthnot Lane. (Lane did not personally promote yoghurt or lactic acid bacillus, but the New Health Society, which he set up, did.)


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work, which forms much of the archive material* on which this research is based. From this, and BMA Archive sources,^ an account is made of the work of the BMA and GMC, the internal conflicts involved, and the CEC's problematic relationship with Lane. In order to construct the account of the public perception of the profession I have also drawn on newspaper sources, particularly The Times. These two areas will be considered before turning to the Star libel case.

**Contexts and Actors**

A central proposition in this account is that to explain the "indirect advertising" controversy reference must be made to two coexisting professional ideals, of gentlemanliness, and of public service. The former had its locus classicus in the Victorian profession, but persisted into the period in question, the latter formed a steadily more important part of the professional ideal through the 20th Century. In these events they are seen to be inconsistent with one another, and form part of opposed opinions. (Those defending the signed articles referred to the more modern position, whilst those who sought to limit them were drawing on the older pattern.) The distinction between arguments deployed and beliefs articulated is, however, frequently unclear. This model of conflicting professional strategies and ideals has been adopted as much to explain the form and style of the debate over indirect advertising, as the events themselves. The term "indirect advertising" (coined by BMA officials) might imply an underlying concern with commercial competition. This aspect of the matter was, however rarely discussed by either side of the debate. This is, in the model proposed, itself part of the process of professional self-definition. The actors in the controversy draw on ideals and strategies for professional life which, while radically different in many ways, share a professed disinterest in financial gain. The main question addressed here is not whether certain practitioners were exploiting an opportunity to make money, but why the GMC and BMA found themselves in difficulties when they attempted to control these activities.

Peterson's account of the mid-Victorian profession^ has shown the importance of gentlemanly attributes and behaviour in promoting individual practice, and in forming and establishing the London medical elite. Entry into this elite required a balance of voluntary hospital and academic position, patronage, both lay and medical, and a practice among well connected patients. It enabled a small number of medical men to secure "connection and sometimes influence with the upper orders of Society" and "a place of institutionalised corporate professional power." It also gave them power over the medical rank and file, their putative "professional brethren", many of whom "struggled on without power, professional respect and often without the economic resources for survival." This use of elitism was an important method of raising the

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*The material is now held by the Contemporary Medical Archive Centre, Wellcome Institute for the History of Medicine, London, (CMAC). The core archive is SABMA D235, Indirect Methods of Advertising. The files pertaining to the libel action are SABMA D106 - 108, BMA v Daily News. Other related files: SABMA D111, New Health Society 1927 - 1935, and SABMA D214, Advertising.

^BMA Archive, BMA House, London. CEC and Council minutes were consulted.


^ibid., p. 192.

^ibid., p. 192.
profession out of the medical marketplace, which placed on doctors the obligation to behave as if they were not concerned with the sordid struggle for income. Paradoxically, the only way in which a doctor could really gain such security was by skilfully exploiting the very marketplace he affected to ignore.

Texts on medical ethics, or on the profession in general, illustrate that between the mid-Victorian period and the 1920’s the appeal to the standards of gentlemanly conduct remained important. For example, Jukes De Styrap, in 1886 wrote, “let us by the impersonation of the scholar, the gentleman, and the christian be respected.” Squire Sprigge argued in 1905 that medical men must “maintain a high code of honour” and defined “considerable success” in practice as “enjoy[ing] more than ordinary esteem and influence in society”. As late as 1926 Sir Thomas Horder declared in a public address, “the unregistered practitioner enjoys perfect freedom, he need not even be a gentleman”. Modern scholars have also described its influence in forming medical theory and practice in the early 20th century.

The pattern of elite practice and power also persisted into the interwar period, as did much of the distance between these men, holding positions of power in the royal colleges, GMC and to an important extent in the BMA, from the rank-and-file of medical men. However the medical profession had also increasingly sought to promote itself in other ways. The ideal of public service, and the winning of state backing and funding are described by Perkin as central features of the rise of the professions from 1880. As scientific public servants doctors were able to win power, influence and security by cooperating in the formation and execution of State policy. Public service in this more modern form gave increasing numbers of doctors increasingly secure practice, although, as is well documented, the profession was divided on its attitudes to State salaried service. Despite the split between the elite and the rank and file in the 1920’s, it would be an over simplification to represent these as two ideals situated exclusively within two portions of the profession. The social and ideological rifts did not always coincide but are interconnected explanations for the controversy over indirect methods of advertising.

This inconsistent and divided pattern of medical opinion can be seen mirrored in wider societal trends. Jose Harris’ account of Edwardian Britain is one of “a ramshackle ....society, characterised by a myriad contradictory trends and opinions”, one in which the population divided itself into innumerably

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11 ibid, p. 30.
16 For example, George Newman, through government office, gained more than just influence with government; by this period he was on the GMC and dined regularly with members of the London elite. (G. Newman, diaries, PRO, MI 139, 3,4,5)
groups and classes. Other commentators, including Hynes, Perkin, and the more contemporaneous Robert Graves agree that the society of interwar Britain was in many ways continuous with that of the Edwardian era, both in features conserved and processes of change.

Other factors form part of the context. One was the body of opinion advocating the teaching of rules of healthy, hygienic living to individuals in order promote the health of the nation overall. Proponents of health education stressed that individuals had to learn certain natural, physiological patterns of behaviour, and that the medical profession were well placed to communicate this knowledge. Thus some doctors made it their concern to provide prescriptions of lifestyle and diet to individuals en masse. In Lane’s words, “widespread education and encouragement of the preservation of health is one of the greatest needs of the present day, and that unless the popular press is available for propaganda, any such effort will be deprived of the best avenue of approach to the bulk of the population.”

The newspaper editors for whom they wrote argued that it was important that the authors were not anonymous, and that their work was presented in an “attractive” way. The Press were active in soliciting much of the material discussed in this debate, and there was a clear overlap in interest and ideals between doctors like Lane, and the Press. Doctors and journalists both referred to the ideal of liberal professionalism (hence the phrase “gentlemen of the press”). Indeed “newspapers show[ed] a tendency towards....writing as if their natural habitat was the chancelleries of Europe.” The conception of the press as “the Fourth Estate” was espoused by newspapermen of the period, framing their interest in forming and informing public debate and policy. This aspiration fitted neatly with the concerns of doctors interested in public health education. Indeed their ideas were framed as much in response to the arrival of the mass media as to the better documented concerns over physical deterioration. The tone of the middle class press, set by papers like the

19 Perkin, op. cit., note 14 above.
21 An early statement of the need for education in implementing public health measures can be found in S. and B. Webb, The State and the Doctor, London, Longmans and Co., 1910, p. 100. “The very aim of the sanitarians is to train the people in better habits of life”. George Newman consistently argued for health education, as in his lecture Public opinion in Preventative Medicine, London, HMSO, 1920. The 1925 Public Health Act made provision for Local Authority funding of health education activities. Following this both the BMA and the Society of Medical Officers of Health (SMOH) looked at ways of systematising and organising public health education, (See CMAC SA/BMAF70). The SOHM published a magazine Better Health, from 1927. A large number of Voluntary Organisations were undertaking health education activities in the interwar period. 23 are listed by Newman in his memorandum Public Education in Health, London, HMSO, 1925.
22 Arbuthnot Lane, letter, The Times, 4.1.26, p. 8c.
23 Horder summed up this situation very well in Horder, op. cit note 12 above.
24 Philip Elliot ‘Professional ideology’ in G Boyce, J Curran, P Wingate (eds), Newspaper History from the 17th Century to the present day, London, Constable, 1978, p. 172.
Daily Mail was such that articles by medical men on health could form part of their effort to inform and entertain. Of course less sympathetic interpretations of the collusion between doctors and journalists can be made and many of these are found in the statements of those who opposed it, as will be demonstrated later.

Advertising was a difficult issue for journalists interested in promoting their occupation as a profession. Newspapers derived half their revenue from, and gave roughly half their space to advertisements. The practice of "puffing": the insertion of copy advertising persons or products into news stories and editorial material, was widespread well into the 20th century. Many papers including The Times and the Daily Mail strenuously resisted the aggressive tactics of advertising agents wanting to place puffs, in order to protect their reputations as independent professionals. "The disguised puff", wrote one Edwardian commentator, "is one the most prominent features of newspaper advertising today. The reader is beguiled into perusing what appears to be a piece of news, and finds he is artfully led into a laudation of somebody's pills or soap."

Indeed, patent medicines were amongst the most commonly advertised articles throughout the late 19th and early 20th centuries. The BMA conducted a consistent campaign against these "Secret Remedies" during the 1900's and 1910's.

The association between advertisements and quack medicine was one of the factors its designation as unethical. De Styrap, in 1886, identified the many methods, some more subtle than others, whereby doctors advertised themselves in the press (he did not include signed articles of the type published in the 1920's), and described them as "the ordinary practices of charlatans, incompatible with the honour and dignity of the profession." The abstention from advertising would also, he argued, serve to emphasise the distinction between the profession and trade. Another reason for the injunction against advertising, and specifically canvassing, was that many Medical Aid Societies and Provident Dispensaries canvassed for patients, and by the Edwardian period the medical agitation against this lay control of medical work was at its height.

Robert Saundby (who was the first chairman of the BMA CEC) considered the only legitimate advertisements to be reputation, and a small plate bearing a name, but no details of speciality. Mentions of doctors by name in newspapers are spoken of disapprovingly as far back as the 1880's, but the specific designation 'indirect advertising' was made in the 1920's. Although the reasons were never stated explicitly, it seems to have been regarded as unethical largely because it smacked of 'puffery' and quackery. The statement that it might attract patients unfairly was unusual, and the problem of medical overcrowding in towns and cities is never mentioned in this connection.

The ethical texts considered thus far, although written by members of the elite, were not formal professional codes, but informal attempts to raise the standards of medical behaviour. We shall now turn to

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26 De Styrap, op. cit., note 9 above, p. 52.

27 GMC, Minutes. XXVI, p. 64, (6.6.1899). See also CEC Minutes 1913 - 14, BMA Archive, B/63/1/2.

consider the GMC and the CEC of the BMA. It is worth bearing in mind that whilst the BMA and GMC are obviously separate organisations, many members of the GMC were prominent members of the BMA. Furthermore the two organisations were often confused by contemporary figures, or criticised as if they were interchangeable.

The General Medical Council

The GMC developed its disciplinary machinery in the 1860's, and a critical account of this development has been given by Russell Smith. The council consisted of 36 members in the early 1920's, all registered medical practitioners, of whom all but six were appointed by the royal colleges, and the universities. The six other members were Privy Council appointees. Cases brought before the GMC were not brought to trial by the Council itself, but were usually referred to them by either the royal colleges, the BMA, the medical defence organisations or the courts, and fell into two categories. The first were doctors charged with criminal or civil offenses originally dealt with by the courts, drunkenness or adultery for example. The second were cases of medical ethical offenses, and it is with this group only that this discussion is concerned.

The GMC was described as a defective legislature and judiciary by many of the correspondents to The Times in 1925 and 1926, including Bernard Shaw and Sir Edward Marshall-Hall. In his well known fictionalised attack on the Council, Cronin characterised it as “a second hand law court”. Smith’s appraisal of its work is also legal in approach, so a comparison with the legal justice system here will serve here to make some important points. There was only one charge available to the GMC, “infamous conduct in a professional respect”, and, admonition aside, the only ‘punishment’ was erasure of the practitioner’s name from the Medical Register. The ‘jury’ were not 12 of the defendant’s peers, but the 36 members of the Council, almost all elite men, who served in this capacity over long periods. Perhaps most importantly the Council gave minimal written descriptions of exactly which forms of behaviour constituted “infamous conduct”. This was in the form of the Warning Notice, which during the 1920’s outlined only seven types of misconduct, and was explicitly not an exhaustive list of ethical offenses. It was possible therefore to be

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33 The most striking illustration of this was at the hearing of William Lloyd’s case (GMC, Minutes, LXII, p. 100, (28.11.28)) in which the BMA were complainants. Council members with BMA membership were asked to leave the proceedings to avoid a possible conflict of interests, leaving only 18 out of the 30 present to hear the case. This overlap included some prominent and active BMA members such as Drackenbury, Robert Bolam and Sir Jenner Verrall, Presidents of the BMA. See GMC Minutes, LXII, p. 1 (26.5.25)


35 A lay member was appointed in 1925, see text, and note 134 below.


37 See notes 118 - 121 and 123 - 127 below. Marshall-Hall was a Sessions Judge and had been Conservative MP for Southport 1900 - 06.

38 Cronin, op. cit., note 2 above, p. 375.

39 The first Warning Notice appeared in major medical journals in 1887. Formal Warning Notices were given to all newly qualified medical practitioners from the turn of the century. The combined Warning Notices revised in 1914, and were printed in the front of the Medical Register from 1920 - 1958. See Smith, op. cit., note 34 above.

40 GMC, Warning Notice, June 1923. “The instances...given...do not constitute, and are not intended to constitute a complete list of the offenses which may be punished by erasure from the Register”. The offenses listed were; 1) issuing misleading or improper Certificates,
struck off the Register for an offence which had never been, and indeed might never be identified in writing or officially communicated to the profession.

But to adopt this critique exclusively obscures other interpretations, for the GMC can be seen as working **effectively** on quite another model; that of the 'gentleman's club'. Indeed the organisation of Edwardian (and thus to an extent interwar) English society can be seen as consisting in a myriad clubs, many overlapping. Even Parliament "retained the atmosphere and habits of a West End Club".\(^1\) In disciplinary terms the 'lever' is the approval (or disapproval) of the group, and the ultimate sanction is expulsion. Discipline is handled by demonstrating the unacceptable nature of the member's behaviour; a hearing before the Council, and the member is either censured, or in severe cases, expelled from the club. This model requires some qualification for although the 'club officials' were elite, entry into ordinary membership was a matter of qualification. The right to remain, on the other hand, required genteel behaviour and the careful avoidance of working associations with healers who were not members.\(^2\)

The existence of an unwritten code which if contravened could result in an all too real punishment, is at one of the most important practical manifestations of the gentleman club ethos. Gentlemen were widely held to understand naturally the ways in which they should conduct themselves. Saundby did not concur with this view, and was in favour of a detailed code of ethics (though he does not suggest it be adopted by the GMC in particular). His comments on the issue are a convenient summary,

"apart from a few resolutions of the GMC, and the Royal College of Physicians, there are few rules.... It is not sufficient to say, as some people do that medical ethics may be summed up in the Golden Rule, or that a man has only to behave like a gentleman.... Moreover what was [once] regarded as customary and even proper....[may] come to be universally condemned."\(^3\)

This last point is particularly pertinent, for the "lex non scripta", like the British Constitution, is capable of radical adaptation whilst retaining the gravitas and authority of tradition. The GMC, of course, used a mix of written and unwritten rules.

Advertising and canvassing, in the lay press or elsewhere, were not proscribed in the 'written law' of the Warning Notice until 1905,\(^4\) but had a swift rise to prominence. Russell Smith\(^5\) has compiled a table of the time taken for an ethical issue to pass from being the subject of hearing before the GMC, to its appearing in written guidelines. The longest lapse between first inquiry and guidance was the 101 years that it took for guidelines on confidentiality to appear. The Council had ruled that advertising was not in itself an offence in

\(^1\) Harris, op. cit., note 17 above, p. 188.

\(^2\) See note 40 above.

\(^3\) Robert Saundby, *Medical Ethics*, (1st Edn.), Bristol, John Wright, 1902, p. 2.

\(^4\) GMC, Minutes, XXXVI, p. 138, (1.12.05)

\(^5\) Smith, op. cit., note 34 above.
1893 making a lapse of 12 years. The issue of indirect advertising was formally brought to the attention of the GMC by the BMA in 1922 and included in the Notice in 1923. This comparative rapidity can be seen a sign of the urgency of this issue, at least partly explained by the general overcrowding of the profession and perhaps also the additional pressure on medical competition consequent on the demobilisation of large numbers of doctors following the Great War.  

The BMA and the Central Ethical Committee

Despite the overlap in membership between the GMC and the BMA outlined earlier there were large differences between them. The GMC was a statutory body which regulated all doctors and consisted of only 36 members of the elite. The BMA on the other hand was a private corporation, an organisation that existed to "promote the interests and honour of the medical profession", and thus represented its twenty four thousand members, in the sense that any professional association or trades union would. These members were from all medical walks of life, including a large number of GPs. It consisted of a central organisation in London, which was in constant communication with local Branches and Divisions, an arrangement with combined "the advantages of a local medical Society with those of an imperial organisation". Its rhetoric and structure aimed to promote a united profession, but as we shall see, it suffered from significant internal divisions.

The BMA formally took on a role in modulating medical behaviour in 1902, setting up the CEC with Robert Saundby as its first chairman. It consisted of 6 members nominated by the Council of the BMA and 6 nominated by the Annual Representative Meeting (ARM). The BMA's President, the Chairmen of the Council and ARM, and Treasurer were also ex-officio members. Its main role was to advise Council on, and supervise the ethical rules of the local Divisions of the BMA, to report to Council on the behaviour of individual practitioners for whom expulsion from the Association was considered, and to arbitrate disputes between individual members. In effect it handled ethical matters that local Divisions were unable or unwilling to adjudicate. In 1920 a standing sub-committee was set up which could meet a short notice and frequent intervals, and much of the CEC's business was handled by it. Many CEC members served on the

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46 GMC, Minutes, XXX, p. 266, (27.11.1893).
47 Every meeting of the CEC for 1919 - 20 considered cases involving this problem, BMA Archive, B\63\3\17.
48 See note 33 above.
49 BMA membership, having fallen during the period 1912 - 1918 was in fact rising steeply during the period addressed here, and was to double between 1919 and 1939; it stood at 22,282 in 1922, and had reached 33,625 by 1927. See P. J. Bartrop, The Mirror of Medicine, a history of the BMJ, 1990, p. 217. This rise in membership was typical of professional associations and trades unions in the interwar period. See Perkin, op. cit., note 14 above, pp. 218 - 285.
50 Sprigge, op. cit., note 10 above, p. 236.
51 BMA Council Minutes, July 1903, p. 11, BMA Archive, B\54\2\11.
52 CEC Minutes, 15.10.20, BMA Archive, B\63\3\17. I have made no distinction between CEC and CEC Sub-committee in the account below.
committee for ten years or more. A great deal of the CEC's policy documents and correspondence were written by the BMA's Medical Secretary and his Deputy.

Can the CEC be included in the disciplinary model of the gentlemanly club? Some features suggest not. CEC members were partly elected by the representatives of ordinary doctors (themselves locally elected). The CEC, in keeping with Saundby's views, made more written rules, and more explicitly, for the profession than the GMC. However, the committee's sanctions were not dissimilar to those of the GMC. It could censure a BMA member at a special meeting, recommend he be expelled from the Association by the Council, and could uphold locally made decisions to ostracise a practitioner. It could only expel a doctor from the profession by bringing his case before the GMC. The basic formula under which these sanctions were brought to bear were as vague and all-embracing as the "infamous conduct" clause of the GMC. A practitioner could be found guilty of "conduct detrimental to the honour and interests of the medical profession". Its ethical rulings incorporated the ethos of gentlemanliness. In its work to promote the profession and modulate the market in medical care, it accepted, articulated and enforced many of the values of the elite.

Sir William Arbuthnot Lane, and the New Health Society.

This is not the place for a detailed account of Lane's formal career, which lasted from 1884 to 1925, and was remarkable but also typical of the times. His most important consultancy was at Guy's Hospital, where he had been a student. Lane preferred to work out his own ideas and methods rather than accept standard theory and practice. He was a controversial surgeon, at the centre of two major areas of clinical debate during his career. The first was the operative fixation of simple fractures, the second was the use of colectomy to treat "chronic intestinal stasis". His reasoning in both areas of practice drew on a general patho-anatomical framework that he claimed to have developed early in his career.

Lane was one of the foremost innovators in aseptic and "no-touch" surgical technique. His operations were, by the standards of the day, remarkably safe. This was a large factor in the success of Lane's private practice, which was generating an annual income of £20,000 per annum by the early 1920's. Contemporary newspaper cuttings describe him as "famous surgeon" or "the best known surgeon in London", by the standards of the day, remarkably safe.

Reginald Langdon Down was chairman from 1919 - 1925, when Arnold Lyndon took over. Other 'long servers' include James Neal (Secretary of the MDU), C O Hawthorne, and N Bishop Harman.

Alfred Cox was Medical Secretary of the BMA from 1912 - 1932, when he was replaced by the serving Deputy Medical Secretary, George C Anderson. Anderson died in office in 1944.

Lane's career forms the basis of Ann Daly's M.D. thesis 'Fantasy Surgery', University of London, 1993.

In the case of bone operations, he rarely caused osteomyelitis, at that time fatal to either limb or patient. He was said to be "the only man in London who could open the abdomen safely." (H. W. Bruce, quoted in Layton, op. cit., note 56 above, p. 105.)

This phrase was used by almost all the papers covering the Lyons' story, see notes 136 - 140 below.
Britain”. He was awarded a baronetcy in 1913 for an abdominal operation on one of the royal princesses, and with title, income, West End address, and large country estate at Glendalough had risen from a relatively humble military background to become a member of the elite of medical men, a medical aristocrat.

Lane gained a high social position, as distinct from institutional influence. This position enabled him, in retirement, to launch his campaign to educate the general public in the principles of healthy living and disease prevention. The New Health Society was a private charity, inaugurated in 1925, and active between 1926 and 1937. The dispute between Lane and the BMA CEC on the issue of indirect advertising provided much of the impetus to set up the Society. The purpose of the Society was to improve the health of the population by providing information on diet, hygiene and the prevention of disease. It reflected Lane’s preoccupation with bowel habit to a certain extent, and seems to have been aimed as much at the middle classes as the urban poor. However the Society was in membership, and in broad concern with national fitness and the habits of life typical of the many voluntary organisations working to improve the fitness of the population. Many of those involved in the Society were involved in other similar organisations. Its founders and members included a wide range of political, medical and commercial figures, and formed an impressive selection of the elite of Society. For example, members included both Lloyd George and Asquith (the former Liberal Prime Ministers), Alfred Mond (later Lord Melchett, first Minister of Health and founder of ICI), George Lansbury (a notorious Labour MP), William Willcox (toxicologist famous for solving the Crippen case), and Henry Wellcome (pharmaceutical entrepreneur and philanthropist).

Concerns of the Central Ethical Committee, 1922 - 1926

In February 1922, the CEC considered what it regarded as a significant disciplinary problem that had appeared in the previous two or three years. “The CEC”, stated a memorandum to the Council of the BMA, “frequently receives letters adversely commenting on notices, articles, books pamphlets, photographs etc which direct public attention to particular medical practitioners, and are likely to have the effect of attracting practice to them even though they are not in the ordinary guise of an advertisement. Journalism for its own ends is always eager to get copy or pictures in which the personal element is strong.... newer journalistic methods are even more insidious and more objectionable. An

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60 Lane did not hold position in the GMC, Royal Colleges, BMA, or medical defence organisations.
61 There were 23 voluntary bodies involved in health education listed by Newman, the most recent of which was the New Health Society, (see note 21 above). See also, G. Jones, Social Hygiene in 20th Century Britain, London, Croom Helm, 1986. Jones categorises these as “Social Hygiene” organisations and the population on whom their efforts focused as “The Social Problem Group”.
62 Examples are Caleb Saleeb and Elizabeth Sloane Chesser. Saleeb was an Edinburgh graduate, and was extensively involved in voluntary organisations, including, amongst many, The World League against Alcoholism, The Divorce Law Reform Union, The Eugenics Education Society, and was a founder member of The Sunshine League, which campaigned for access to sunlight, heliotherapy and outdoor physical culture. See Medical Directory, London, J & A Churchill, 1924, and New Health, 1927, 2, October issue. Elizabeth M Sloane Chesser, was a Glasgow graduate, with a Harley Street practice specialising in the diseases of women and children. She was a lecturer for the National Council for Combatting Venerable Disease, and the British Red Cross Society. She edited Health and Psychology of the Child and published a popular book Women, Marriage and Motherhood. See Medical Directory, 1924.
article on some indifferent subject may introduce without any obvious point a casual laudatory allusion to someone's professional work."^63

The memo also alluded to the difficulty of dealing with cases “which sometimes involve men of high standing”. The Committee wanted the BMA to approach the GMC for a more explicit ruling than that of the existing Warning Notice of May 1905.64 Although this rule did not make any comment on the appearance of practitioners’ names with newspaper articles, the CEC had been concerned with the ethics of doctors publishing their names since from its earliest days. They had discouraged the publication of named interviews,65 named articles,66 addresses, and photographs.67 Books on medical matters could give the author’s name, but not address, and advertising for these books could make no claims on behalf of the book or its author.68 More explicit forms of advertising had been censured, including the placing of change of address notices in papers.69 They regarded their rulings as upholding the principle of the Warning Notice, but none of the activities were explicitly forbidden.

The committee objected as much to the description of the doctor, as to the use of his name, especially if the doctor was presented as offering superior treatment, or described as a “specialist”.70 Their documents describe the matter as a subtle one, for “things which are innocent in themselves may by the manner and frequency of their doing gravely contravene the principle that medical practitioners should not advertise.”71 A document produced by George Anderson (then Deputy Medical Secretary), described the problem in terms of social and occupational distinctions,

“[These] journalistic developments .... seem .... likely .... to undermine some of the most cherished traditions associated with the Medical Profession in this country and to lower its reputation among the more thoughtful sections of the community. ....Means of personal advancement .... legitimate in Politics or the stage .... have, in the past, been shunned as undignified to say the least by the Medical Profession.”72

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63CEC minutes, 15.2.22, Memorandum to BMA Council, unnumbered folio, CMAC SABMA D235. ("D235").

64GMC, Warning Notice, 1905. “The practice of (a) advertising by a registered medical practitioner with a view to his own gain, particularly if depreciatory of other practitioners, or of sanctioning such advertising, of (b) employing or sanctioning the employment of agents or canvassers for the purpose of procuring patients and of (c) associating with or accepting employment under any Association which practises canvassing or advertising for the purpose of procuring patients are .... contrary to the public interest and discreditable to the profession of medicine and any registered medical practitioner resorting to any such practices renders himself liable .... to have his name erased from the Medical Register.” See note 44 above.

65CEC Minutes: min 19 1904, unnumbered folio, D235.

66CEC Minutes: min 89 1910, unnumbered folio, D235.

67CEC Minutes: min 29 1918, unnumbered folio, D235.

68CEC Minutes: min 29 1908, unnumbered folio, D235.

69CEC Minutes: min 29 1918, unnumbered folio, D235.

70CEC minutes 26.9.22, unnumbered folio, D235.


72Ibid.
Despite the obvious implications for medical competition the matter was largely described as a contravention of 'form', tradition or dignity. For instance Anderson stated that many of these questions might be "settled by an appeal to good taste". The BMA looked partly to gentlemanly behaviour to modulate potential rivalry between doctors, as is clear in a handbook in preparation at the same time. Describing a doctor's duties to his "professional brethren" it said,

"Under a condition of matters now happily disappearing, members of the profession regarded themselves simply and solely as rivals. [We are] now learning [that] there is amply [sic.] room and necessity for friendly co-operation. Men who 'play the game' can nearly always depend on the same treatment from others."

The committee judged that such an approach needed to be supported by definite statements. The BMA Council on the recommendation of the CEC asked the GMC for a new Warning Notice. They were turned down, the GMC preferred instead to have the BMA bring a "flagrant case of any new offence" to them. The CEC considered taking the initiative, by issuing a statement of their own that signed articles on medical matters in the lay press were "incompatible with membership of the BMA". This was considered "inexpedient", and instead the committee resolved to "maintain an attitude of watchfulness...[and to] intervene on any occasion when it [seemed] wise to do so". Press Cuttings agencies were subsequently employed to monitor such articles. This was a departure from usual role of the CEC to await complaints from members or Divisions. Although there is no direct evidence that any prosecutions resulted, at least two cases discussed later, which resulted in erasures from the Register, were 'discovered' in this way.

The Council of the BMA repeated their request of the GMC, this time expressing one of the major concerns of the CEC; that without firm steps it would "be increasingly difficult to maintain the discipline of the profession without producing a feeling of injustice." This second request was successful. The Warning Notice of June 1923 was reworded to include advertising "indirectly", and the concept of acquiescing to publication.

The Committee then worked on a detailed set of guidelines to communicate to BMA members just how they were to behave in this area, and to make the new Warning Notice a workable tool for control. The

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73ibid.

74draft, BMA Handbook for Newly Qualified Medical Practitioners, 1922, p. 10, CMAC SA\BMA A17.


76CEC Minutes: 20.5.22, unnumbered folio, D235.

77This may have become a confused rumour since later in 1925 an anonymous letter to The Times (5.12.25, p. 8c) alleged that the GMC employed such a method of monitoring the Press, an allegation that was subsequently denied (Norman King, letter, 16.12.25, p. 10c.).

78BMA Council minute 6.5.22, unnumbered folio, D235.

79GMC Warning Notice June 1923, (extract). "The practices by a registered medical practitioner a) Of advertising, whether directly, or indirectly for the purpose of obtaining patients, or promoting his own professional advantage, or for any such purpose, of procuring or sanctioning, or acquiescing in the publication of notices commending or directing attention to the practitioner's professional skill, knowledge, services or qualifications or depreciating those of others; or of being associated with or employed by those who procure or sanction such advertisements or publication or b) of canvassing or employing any agent or canvasser for the purpose of obtaining patients; or of sanctioning or of being associated with or employed by those who sanction such employment; are .... (remaining wording unchanged, see note 64 above)
final form of the BMA Report on Indirect Advertising did not forbid the signing of articles, but allowed no
“editorial extravagances” in connection with the name of the doctor concerned, (see footnote ). However, in
1924, before the CEC had decided whether or not articles had to be entirely anonymous, they considered a
number of newspaper articles by doctors, apparently to find a good test case for themselves and the GMC.80

Six articles were considered, but two were thought “not clearly advertisements” by Hempsons, the
BMA’s solicitors. The outcomes of the remaining four cases demonstrate some of the difficulties faced by
the CEC in dealing with members of the elite or those connected with them. That of Sir Bruce Bruce Porter81
was felt to be the right sort for prosecution, but was dropped following discussions with GMC, with whom
Porter had already corresponded. A subsequent article was also excused, despite its carrying his photo and
qualifications.82 Two more cases were referred to the Marylebone Branch of the BMA who attempted, twice,
to pass the cases back up to the CEC, who were eventually to deal with both. One of these, an article by
Hayden Brown entitled “Childbirth: Amazing New Discovery”,83 went to the GMC and Brown was struck off
the Register.84 The second was that of A. White Robinson, who had published and article, “Keeping Cancer
Away”.85 This case demonstrates what CEC member C. O. Hawthorne described as a conflict between the
“judicial” and “parental” modes of enquiry. Here Robinson was asked in the “informal”, “parental” way to
account for the article. It transpired that The Weekly Dispatch had asked Robinson’s friend, William
Arbuthnot Lane, for an article, owing to public interest in the publication of a book on the prevention of
cancer,86 and Lane had recommended Robinson. Robinson expressed surprise and contrition at the turn of
events, claiming not to have known his actions were wrong,87 and his case was taken no further. Hawthorne
considered that an initial “parental” approach made a switch to “judicial proceedings....manifestly unfair”.88

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80 CEC minutes for 14.7.24 and 23.9.24, unnumbered folio, D235.
81 B. Bruce-Porter, “Publicity and the Medical Profession”, Sunday Express, 6.7.24. Bruce-Porter had trained in London, Brussels and Vienna,
and at various hospitals including Netley (in 1893). In 1916 he commanded the 40th British General Hospital Expeditionary Force. He also
had been Consultant Physician to the King Edward the VII Hospital, and President of the Hunterian Society. He was later closely involved with
Lane in writing and lecturing behalf of the New Health Society. See Medical Directory, 1925.
83 Anon., John Bull, 19.7.24. This article dealt with his “neuroinduction” technique for banishing the debilitating effects of fear in childbirth.
William Hempson considered it “an unadulterated advertisement....for personal self-advancement”, CEC minutes, 23.9.24, unnumbered folio,
D235.
84 GMC Minutes, LXI, pp. 65 - 6, (25.11.24). No complainant is mentioned in the Minutes. My conjecture is that this case was either
instigated, or brought by the BMA, as a result of their monitoring of the press.
85 Weekly Dispatch, 6.7.24. Unaccountably “A. White Robinson” does not even appear in the Medical Directory, all that can be said about him
is that he had a Harley Street practice and was described in the headline for this article as “A Specialist in Diseases of the Blood” (a designation
that offended the CEC).
86 J. Ellis Barker, Cancer, how it is caused and how it can be prevented. London, John Murray, 1924, with a foreword by Lane. Lane had also
helped with the main text of the book which argued for dietary reform and the elimination of toxins from the body. Barker (originally named
Otto Julius Eltzacher) wrote widely on homeopathy and healing as well as political economy and international affairs, and became a member
of the New Health Society.
87 CEC minutes 6.1.25, unnumbered folio, D235.
88 Letter from C. O. Hawthorne to Anderson, 17.7.29. Unnumbered folio, CMAC SA/BMA/D151. Several elite doctors had given their names,
photos and testimonials to a advertising campaign for a proprietary yeast, Fleischmann’s. There was evidence that the men were handsomely
paid, but because the CEC approached them first asking simply for an explanation, they were frequently able to state that the adverts had
appeared without their full consent.
The last case, sent to the Surrey Branch of the BMA was Cecil Webb Johnson. The Council of this branch had already written to the CEC concerning a previous case, having been much impressed with the large number of cases brought to [our] notice by Dr X in which prominent members of the profession appeared to be guilty of the same offence as that with which he was charged. We hope that the Committee may find it possible to take action against the more eminent offenders in order that a charge so often made that the Association penalises the more humble GP and allows the Consultant to go free may be refuted.

The Surrey Branch did not punish Johnson. These examples demonstrate the many ways in which supposedly similar cases could resolve, and that the Association appeared to be making unfair social distinctions in its disciplinary rulings. Despite their efforts to avoid “a feeling of injustice”, including the seeking of written guidelines from the GMC, they were creating one nevertheless.

The CEC and Sir William Arbuthnot Lane

Webb Johnson himself wrote to the committee on New Year’s Day 1925 to point out this “unfairness” (this was not his first or last letter of compliant to the CEC, but is representative of them). There had been a flurry of publicity surrounding an article by Lane which appeared in a medical journal in December 1924, entitled “Cancer; its origin”. Johnson sent cuttings mentioning Lane from three newspapers, as well as an article by Elizabeth Sloane Chesser. The following will give some idea of the style of the interviews Lane gave, and of the way they were often reported:

“DOCTOR CRITIC OF MODERN WOMEN \ POOR CREATURES SHEATHED IN RUBBER \ HOW TO LIVE PROPERLY \ SIR W. A. LANE’S COMMITTEE TO TEACH NATURE’S LAWS

‘Women reared on natural food and in accordance with nature’s laws would not barter their sex in a mistaken attempt to attract the admiration of men in a ballroom.’ ‘The time is not ripe for any definite announcement but I will say that a number of important people are forming themselves into a committee. Their object is to educate public opinion on the subject of proper feeding and attention to natural laws.’

(This latter comment is the earliest reference to the idea of the New Health Society.) Webb Johnson challenged the CEC to discipline Lane. He also wrote a more revealing letter to Dr Lyndon, who was

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Secretary of the Surrey Branch, but also (and Johnson clearly did not know this) Chairman of the CEC. In this second letter Johnson said of the cuttings he had sent in,

"Had I or any other GP been guilty of this there would have been an investigation, but of course Sir Arbuthnot making his £20,000 a year dare not be touched. There is nothing personal in this letter as Sir William is a friend of mine and dined with me last Sunday. My objection is a matter of principle and justice...men like Lord Dawson, Sir Arbuthnot Lane, Sir Bruce Bruce Porter and many others [are] being allowed to do what they like while GPs guilty of smaller offenses are victimized."

He further alluded to the "indignity" of his earlier enquiry in 1924, and put his acquittal down to the members of the Surrey ethical committee being "gentlemen and sportsmen out for justice and fair play", the (rather unfortunate) implication being that the CEC were not.

Johnson’s was not the only voice raised in such accusations. A letter in the BMJ a few weeks previously, from Harry Roberts, a prominent socialist East End GP had called for the profession “to express itself with some approach to definiteness on the question of medical publicity. ..... Small men are haled [sic] before the [GMC] and either patronizingly censured or removed from the ranks of the profession for two guinea contributions to the weekly press, whilst the hundred guinea contributions of their big brothers to the daily press are tolerated without comment.”

He went on to describe an example involving Sir Thomas Horder and concluded, “Sauce for the gosling should be sauce for the gander.” and expressed confidence that Lane “as a member of the Association” would

The CEC then had before it these challenges, and the cases of Lane, Sloane Chesser and Horder. They took no action against Horder, and wrote to Chesser and Lane. The correspondence between Anderson, on behalf of the Committee, and Lane was to be lengthy, and later considered important in connection with the libel case. Anderson’s first letter drew Lane’s attention to the articles, and stated the (as yet unfinalised) ruling on indirect advertising, and expressed confidence that Lane “as a member of the Association” would

84Johnson’s practice address was in Harley Street, placing him somewhat above the “ordinary”.

85C. Webb Johnson, letter 1.1.25, unnumbered folio, D235.


87The book How is your heart? by Calvin Smith advertised on its dust jacket “With an introduction by Sir Thomas Horder Bart MD FRCP”.

88Roberts, op. cit., note 96 above.

89G Anderson, letter 10.1.25. CMAC SAIBM A D106. The correspondence between the CEC and Lane is reproduced over and over again in various documents, including BMA Council Minutes.

100The guidelines continued with a further comment, which, for obvious reasons, was not sent to Lane, “13) Speaking generally, it may be said that the medical men most often quoted in the Press are not those whose opinions carry most weight with the medical profession or with the educated public. It is natural that those whom the Press representatives most eagerly seek to draw into
help “to maintain a proper standard of medical ethics...by conforming to the policy stated.” Lane replied thanking the committee for their “letter or circular” and asked, perhaps mischievously “what [do] you suggest one should do when one finds one’s name being used without permission....Must one take legal action or will the B M A act if applied to?” Anderson replied that the articles in question had evidently been published with Lane’s approval, that similar articles had been cited as a plea of justification in another case, and reiterated that it was a practitioners own responsibility to ensure that their articles were presented without “editorial extravagances”.

Lane wrote no letter in reply but made his thoughts clear in a public speech, given on the 5th June 1925. His comments were reported widely the next day. He said that “the future of the medical profession lay in the prevention of disease” and discussed his plans for the New Health Society, which might be described as “a suicide club for doctors...because as the public became educated in matters of health there would be less disease for doctors to cure.” However, he went on, those engaged in this work were obstructed because,

“if a doctor wrote to the newspapers and signed his name some branch of what was called the Ethical and Medical Committee was down on him at once and he received a rude and insulting letter. He was asked what right he had to write to the papers. ....the Public....[had] to insist on their right to hear what was the truth. The Ethical Committee of the B M A was a self-constituted body which had no business to exist. The conditions here [in contrast with those in the USA] were perfectly absurd and wicked. The whole of the medical profession was at fault for putting up with this sort of thing and it was the fault of the lay Press too because they had only to speak out to alter the conditions.

(cheers).”

Anderson wrote to Lane and pointed out that these comments had been made in a setting where no reply was possible, and requested permission to publish their previous correspondence in the BMJ. Lane replied that it had not been his intention to “suggest that the letters in question were rude”, but that he “could not agree with the action taken by the Committee”, and that if “such expression of opinion is forbidden to members, I can only express regret and tender my resignation.”

Anderson then wrote asking for clarification of Lane’s reasons for resigning from the BMA, but received no reply. A reminder prompted Lane to apologise, for he had “unfortunately mislaid” the first letter,

their service and utilise for their own advantage are those who have some recognised position or well-sounding address or title. It is, therefore, especially important that a stand should be made by such practitioners, who perhaps do not realise that the example set by them may well be pleaded in justification by those in a less prominent position.” “Indirect Methods of Advertising”. Br. med. J. 1925, ii, supplement 11.4.25.

[101] W. Arbuthnot Lane, letter 12.1.25, D106.

[102] G. Anderson, letter 7.4.25, D106. The long delay, and the appearance of several drafts of this letter in the file suggest the Committee was proceeding with some caution.

[103] The occasion was a luncheon for the Inter-State Post-Graduate Assembly of America at the English Speaking Union.

[104] Daily Telegraph. 6.6.25.


[106] W. Arbuthnot Lane, letter, 1.7.25, D106.

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of which he had "no distinct recollection" and to say that he did not "want to be a party to any more
correspondence." Anderson then reminded Lane of "The Code" which was "not peculiar to members of the
medical profession" and which prescribed only two alternatives, substantiation or retraction of his
comments. Lane made no reply

Although the CEC had been publicly slandered, and had written in such strong tones to Lane, even at
this point they chose not to pursue him directly by taking him either to the GMC, for indirect advertising, or
to court, for slander. They decided instead to publish a "Current Note" in the Journal, stating that Lane had
"attack[ed] the status, the policy and the proceedings of the CEC" and had refused publication of his
correspondence with them. Furthermore they took legal advice on the contents of the Note from their
lawyers. Meanwhile on the 11th of December, the month in which Lane’s membership of the BMA expired,
the New Health Society was launched at a luncheon at the Aldwych Club. Speeches being made by Lord
Oxford and Asquith (the former Prime Minister), and Philip Snowden MP. The objects of the Society were
"to teach the people the simple laws of health", encourage the supply of fresh fruit and vegetables, and "to put
the people back on the land". The main method whereby information on hygiene and diet was to be put
across to the people was through the medium of lectures and articles by medical men. Not only did the
Society expressly ignore the ethical ruling of the GMC and BMA, but had amongst its members many doctors
familiar to the CEC.

Press sympathy with the aims and methods of the organisation and disapproval of the BMA and
GMC are clearly expressed in an article in the Daily News.

"SHOULD DOCTORS TELL? \ POINTING THE ROAD TO HEALTH \ BAN MUST END \ CHALLENGE TO THE GENERAL MEDICAL COUNCIL \ "to make the medical profession more
of a lighthouse than a lifeboat" Mr Philip Snowden MP \ THE FIGHT FOR PUBLICITY".

The BMA was described as "frankly out to protect the incomes of doctors, .... its battle with the
Government .... over the Health Insurance Act is too fresh in the public memory to admit of that fact being
obscured" The article went on to describe the rulings of the GMC and BMA, and the difficulties faced by the
Society. In order to protect the medical authors of articles published under its auspices, the Society was

107 W. Arbuthnot Lane, letter, 5.8.25, D106.
110 In a letter to Anderson, C. O. Hawthorne complained, "I cannot say that Mr Hempson is very helpful. Indeed he seems to have a strong
opinion that we should do nothing at all." Unnumbered folio, CMAC SA\BMA\D106.
111 W. Arbuthnot Lane, autobiography, 1936, p. 42a, CMAC GC\127\A1-2.
112 The "founders of the New Health Society" are listed in New Health, (October 1927 for example) and the BMA files. Those known to have
come to the attention of the CEC for indirect advertising are Sir Bruce Bruce Porter, A. White Robinson, Leonard Williams, and Elizabeth
Skane Chesser. (Leonard Williams was the editor of the MPU journal Medical World and controlling editor of Medical Press and Circular; he
also wrote popular health books including The Science and Art of Living. See Medical Directory. 1925 and Honigsbaum, op. cit., note 15 above,
p. 275.) Others known to have been brought to the attention of the Committee who do not appear to have joined the Society, William

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planning to attach a note to such articles to demonstrate "that a number of [the author's] colleagues do not consider that it convicts [him] of 'infamous' professional conduct." Newspapers however did not like the note which "diminishe[d] the attractiveness of the feature by stamping it as health propaganda. People", the article said, "suspect what they know is intended to do them good."  

The BMA took no direct action against the society but a BMJ leader by Dawson Williams, the Editor, entitled "The Medical Pundits" was disdainful not only of the medical men involved, but also their audiences and the press.  

One of the curious phenomena of our present-day social life....is the amount of space the newspapers give to medical pronouncements on everyday matters. Why do they do this? The explanation must be that their readers like it. And why do some of our eminent colleagues scatter these gems of wisdom at public and semi-public meetings and in the course of interviews with reporters? It must be from a high sense of duty....In their hearts they hate publicity; but they know the truth about such things as rubber corsets, shingled hair, high heels, cocktails and (like brave fellows) they are determined to speak out for England's sake. ....if highly decorative members of our profession are so obliging as to furnish good copy, why not make the most of it with the aid of headlines and portraits? Thus lip-service is paid to Hygeia, and a Million blameless citizens are entertained at small cost, as they go to and fro in trams and trains.  

The article continued with unflattering accounts of interviews, articles and lectures by Lane and Bruce Porter, thought neither man was named in the published editorial, the cuttings included in the files make this identification possible. It is not clear how easily a contemporary reader could have identified them. Their names may have been kept from readers in order to avoid libel, or perhaps as a gesture of admonishment.  

We have seen how the CEC found difficulty in dealing with ethical offenses by titled doctors. Why was this? Cronin's dry observation quoted at the head of this paper expresses the answer with great directness. If Medicine is a gentlemanly institution, it is not a simple thing to expel members who are, in all respects other than their offence, demonstrably gentlemen. What indeed would the Register be without Lane, Porter, Horder, Dawson, Bland Sutton and the rest? There would appear to have been a threshold of status beyond which a practitioner could, if he chose, ignore the rules in favour of another set, which Lane had evidently crossed. Members of the elite who disobeyed rules made by the elite were in an ambiguous position, whereas non elite offenders were simply that. There were problematic class issues in a supposedly united profession. GPs looked to the BMA to champion their cause, but found that its project for the profession was not always pitched at their level. "Humble medical journeymen" might find themselves, whilst being expected to attain a certain level of professional gentility, penalised for acts that were ignored when carried out by "medical baronets".  

To challenge the authority of the club Lane had not only use the rhetoric of health education and public service. He had also gathered about him a large group of men, whose collective authority as gentlemen

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114 The term "medical pundit" was being used around the BMA months before this. A rare handwritten note survives dated November 1925 from Gerald Homer (editor of the BMJ) to Anderson about an open letter by Lane promoting The Practitioner. "Thanks. I will bear Lane's outrageous puff in mind, but it is outside the scope of medical punditry I think." Unnumbered folio, CMAC SA\BMA\D106  
115 Br. med. J. 1926, i, 387.
(medical and otherwise) was sufficient to protect themselves and the humbler practitioners allied to them from prosecution by the original club. In looking to the wider public perception of the profession we find the BMA and GMC relying too much on their traditional elitist authority and failing to demonstrate a commitment to the public interest.

**Attitudes to the BMA and GMC as evident in The Times, 1925 - 1927**

A consistent focus of debate in late 1925 was the GMC’s refusal to reinstate on the Register Dr F. W. Axham, who had been struck off in 1911. Axham had acted as anaesthetist to Herbert Barker, the famous lay manipulative healer. The GMC found him guilty of “covering an unqualified practitioner” and his name was removed from the Register. Barker was knighted in 1925 following a petition from four (registered) surgeons. The question then arose as to whether Axham could really be held to have acted wrongly in making Barker’s treatment less painful. Letters to the Times argued for the restoration of Axham’s name to the Register, because, amongst other reasons, the public regarded his work as a service, and because this was necessary to restore the honour of the GMC, as much as Axham’s.

The most prominent contributor to the debate was George Bernard Shaw who argued, hyperbolically, that the GMC must hold that the four surgeons, in associating themselves with an unqualified practitioner were “guilty of infamous professional conduct in which they were aided and abetted by the King”. He claimed that the Council was “victimising” Axham because it could not act against “the King and his advisors. Furthermore, in his opinion the GMC had “become a Trade Union of the worst type - in which the entry to the trade and the right to remain are at the mercy of the Union.” and that it was “at the crude stage of preoccupation with earnings and sullen defiance of public opinion.” He went on to call for the replacement of the Council membership with representatives of the public and the “disinterested hygienic sciences”.

A Leader writer largely agreed with Shaw and bringing in the advertising issue, went on to say “recent decisions made the GMC on the subject of communication by medical men in the press have furnished those who hold this view with arguments which...are at least plausible. .....the Council appears unduly anxious lest any physician may by the gift of exposition obtain what is called an indirect advertisement. It is a short step from [this] to a censorship of opinion.”

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138 GMC Minutes, LXVIII, pp. 52 - 4, (24.5.11).
137 It is perhaps unsurprising that Lane was one of the four, the others being Sir Henry Morris, Sir Alfred Fripp, and Sir Bruce Bruce-Porter. They had petitioned the Prime Minister in a letter dated 5.11.21. CEC Minutes, B63\10, 31.10.22.
140 Cecil Jennings, letter, The Times, 20.10.25, p. 10e.
142 leader, The Times, 26.10.25, p. 15e.
The debate continued for several months, and concerned not only the details and principles of the
dying Dr Axham’s plight, but many related issues. These included the registration of osteopaths; the
lack of freedom of expression of opinion in the medical press; the question of whether public or profession
should decide the merits of therapy; the lack of appeal structure in the GMC; and the unrepresentative
membership of the Council. This debate did nothing less than question right to power of the organised
profession of medicine. Despite this the GMC, per se, made little response except to make technical points,
and the BMA made none at all.

In December 1925, William Lloyd was struck off the register, on the grounds of indirect
advertising. He had been the subject of an article recommending his naturopathic treatment of hay fever,
which had not named him, but had given his clinic address and times. Lloyd claimed the article was the
spontaneous response of a grateful journalist patient. The BMA who brought the case, stressed that the article
recommended a treatment the value of which the public were ill placed to judge. (There is a large overlap in
the cases discussed in P. S. Brown’s study of medically qualified naturopaths and the GMC, and the cases of
indirect advertising during this period.

The Times commented on Lloyd’s erasure in a leader entitled “Doctors and Advertising”, which stated,

“The BMA...is a doctors club concerned primarily with the interests of its members. Its contention
that ‘the public is ill placed to judge the true worth of scientific opinions’ is not therefore surprising,
though the medical profession itself, through its attitude to Harvey, Pasteur and Lister and to a host
of lesser discoveries, has shown itself sometimes less well qualified in this respect even than the
public.”

Turning to the GMC, the leader referred to its having been set up “as a statutory body by Parliament
to preserve the public interest”, and asked,

“Has the GMC lost the ability to discriminate between the professional and the public interests? The
Council consists entirely of Doctors though Parliament intended it should be composed in large part

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122 When Axham died in April 1926, his name was still off the Register.
123 E. T. Pheib, letter, The Times, 6.11.25, p. 10e. These references are to one particularly clear example of a point. Many were made often, in
different ways and in different contexts.
125 leader, “Dr Axham once more”, The Times, 1.1.25, p. 13e.
126 anon, letter, The Times, 2.11.25, p. 15e.
127 leader, The Times, 26.10.25, p. 15e.
128 GMC Minutes, LXII, pp. 99 - 101, (28.11.25). This case was also ‘discovered’ by the BMA’s monitoring programme. This is clear, since
they were formal complainants. See note 33 above.
Brown (1924), and R F E Austin (1928). Both Lloyd and Hayden Brown were cases brought by the BMA as part of their campaign on indirect
advertising. A possible explanation for this association is given later in the main text.
of laymen. It has...lost touch with that public opinion which it serves. The moment is certainly opportune for a reconsideration of its powers."130

The most extraordinary denouncement of the GMC came in a letter from Gordon Ward,131 a GP in Sevenoaks, calling for a parliamentary inquiry,

"Most [members of the GMC] hold scholastic posts and have never experienced the difficulties of actual practice. Of these not a few find....a trial somewhat tedious and....fill in the time by attending to private correspondence. ....The authorities....have thoughtfully provided a post box in the trial room itself. Thus the defendant, already penalised by having to address a jury of 40 is further disconcerted by the occasional rising of on the 40 for the....posting of a letter."132

Questions were asked in the House of Commons about the GMC's membership, disciplinary style and lack of appeal structure on the 3rd, 8th and 14th of December.133 On this latter occasion a full inquiry was refused on the grounds that no doctor had applied to the Privy council for one. A lay member was however appointed to the GMC in May 1926,134 but it was denied in Parliament that this was in response to the Axham case.135

The BMA and the GMC entered the year of the General Strike frequently described in the press as Trades Unions. This is an intriguing insult. The Strike marked the expression of tensions between the many classes and interest groups in society as class distinctions were gradually eclipsed by the rising occupational groupings of professional societies and unions. Among the 'threats' to the social order were those of organised occupational groups exerting power and control to the detriment of the perceived greater public good. The attacks on the institutions of the medical profession centred on the perception that institutions were self-serving rather than performing public service, and these motives were seen as those of a Trades Union. The GMC and BMA did nothing to attempt to change this perception. Indeed a Times leader in June 1926, referred to the president of the GMC's remarks that the Council had stood firm to its critics in the way that the Government had resisted the General Strike as "A Startling Claim". Even in the columns of the Times it is clear that the BMA and GMC were seen by some doctors and laity as wielding too much control over therapy and access to medical knowledge. In addition they were seen to deal with these in ways that were restrictive, high-handed, unreasonable, and even ungentlemanly.

130leader, The Times, 1.11.25, p. 15e.
131Ward, despite conservative political sympathies, was a prominent supporter of a salaried medical service. See Honigsbaum, op. cit., note 15 above, pp. 183 - 4.
133see The Times, 15.12.25, 9e.
134Sir Edward Hilton Young, later Lord Kennett.
135The Times, 9.7.26, p. 10b.
The themes that have been examined so far came together in the Star libel case. The article “Doing without it” was in many ways simply a less subtle replaying these arguments, triggered by the activities of Lane and the New Health Society.

The Lyons Tea Room Affair, August 1926

The New Health Society was collaborating with Lyons in at least two ways in 1926. Lyons were opening a cafe, called the “Vita-Sun Cafe” at which health foods would be available and their vitamin content rated on the menu, and the Society also provided articles on healthy eating for the menus of their chain of restaurants. A photograph of Lane was obtained by Lyons and reproduced next to an article by him on “The Athlete’s Diet” on 40,000 menu cards throughout London. The Society requested that the photo be withdrawn, anxious to avoid further conflict with the BMA. As we know, Lyons staff removed the menus from the tables during the lunchtime rush on the 26th August, and then returned them having covered Lane’s portrait with slips of gummed paper. Several newspapers ran the inaccurate story that the BMA had censored the menu and that Lane had in consequence resigned from the Association. Typical headlines were “CENSOR IN THE TEASHOP”, and “SURGEON BARONET RESIGNS” and “FAMOUS SURGEON FLOUTS BMA \ LIBERTY TO CONDUCT A HEALTH CRUSADE \ MENU COMEDY”. Anderson wrote to most of the papers concerned to correct this on the 2nd and his letter of course prompted a further round of articles on the 3rd. However two articles published on the 2nd attracted the particular attention of the BMA. The first, in the Daily Mirror commented that “the BMA are....ready as ever to prevent the public from getting free advice about health from those who realise that there are more effective pulpits than the consulting room”. The Star’s piece went closer to the bone;

“[the] expressive figure of speech about the man who ‘bites off more than he can chaw’[sic]....might be applied with justice to the BMA. While it confined its oppressive activities to bone setters and other unregistered practitioners who could be dubbed quacks without fear of legal reprisals it was able to get away with it ....When however it tried to discipline distinguished members of its own body it did in fact bite off more than it could chew. Sir William Arbuthnot Lane the President of the New Health Society is the case in point at the moment. The BMA does not like the Society for its motto is ‘Prevention rather than Cure’ To preach ‘Health without Doctors’ is the unforgivable sin to the medical monopolists.... Sir William....had the courage to defy these out of date conventions and contemptuous of the BMA’s power to strike him off its register is reported to have struck himself off. The BMA can do - just nothing.”

Hempsons regarded these both as "grave libel" upon the Association, and both papers were asked for an ample apology and expression of regret coupled with a complete retraction of the insinuations contained in the [articles] or face proceedings. The Mirror published an apology on the 7th. The Star did not, and so the BMA’s lawyers issued a writ against them, and work began preparing the Association’s case.

That Lane "struck himself off" requires some clarification. The BMA of course had no "Register", the Star journalist has in mind the GMC’s Register, and has confused the two organisations. Sadly the confusion did not end there. Both Lane’s biographers state that Lane removed himself from the true Register in order to carry out his work for the Society unhindered. Lane himself said that he removed his name from the Register, and implied that it was at the time when the Society was started up. In fact Lane remained in practice and was registered until 1932. GMC minutes for November 1932 record that Lane had requested “the removal of his name....on the ground that he had ceased to practise”, and that the request was allowed. Perhaps Lane used this confusion to his advantage (that is, if he did not instigate it), given the public’s perceptions of the GMC it would have added to his popularity in some quarters.

The outcome of the Star case, September 1926 - November 1927

BMA staff compiled material pertaining to the issue of indirect advertising, and in particular the dispute with Lane. They also gathered evidence of the BMA’s interest in preventative medicine. In this connection they included every committee report that even tangentially involved prevention of disease, one particularly disingenuous example being the Association’s Report on Simple Fractures. This was not only clearly a curative area, but was also one of Lane’s main contributions to surgical practice. The Association assumed that a “close and inseparable relationship....exists between the interests of the medical profession and [those] of the General Public”, and regarded this as “fact” not requiring proof.

Hempsons, the BMA’s lawyers, sought the advice of a barrister on their evidence. He regarded as most serious the allegation that “the BMA does not like the New Health Society for the reason that the latter’s motto is 'prevention rather than cure'. Indeed, in the absence of this allegation the Plaintiffs might hardly thought it worthwhile to bring this action.” He advised Sir George Newman as a key witness.

143 There are several versions of this apology altered successively in what appears to be the hand of William Hempson, the BMA’s solicitor. Unnumbered folios, D107.

144 See Layton, op. cit., note 56 above, pp. 123 - 4, and Tanner op. cit., note 56 above, p. 147. Layton also records some confusion over whether such a voluntary removal was permissible.

145 W. Arbuthnot Lane, autobiography, CMAC, GC\127\Al-2 p. 43).

146 Sir Thomas Horder, letter to Alfred Cox, 15.7.29, unnumbered folio, CMAC, SA\BMA\D151).

147 GMC Minutes, LXIX, p. 160, and p. 64.


150 Henry C. Dickens, 'BMA v Daily News, Advice on Evidence', unnumbered folio, D108. This was not the Sir Henry Dickens who had been the GMC’s first Legal Assessor in 1881.
stating that he could say how the BMA had worked along the principles set out his “Outline of the Practice of Preventative Medicine”.

Both legal opinions available to the BMA stated that they had a good case. Despite this, it fell apart over the next few weeks. The plan had been to call on a number of eminent men to give evidence for the BMA. One, Lord Dawson, telephoned Alfred Cox on the 27th October, saying, “I have come to the conclusion that the bringing of this Action to court....will damage the BMA whatever the verdict may be and damage the profession. I do beg of [the BMA] to think long and wisely before they go further.”

Dawson wanted “go-betweens” appointed to “induce....the Star....to do the honourable amend”. Newman wrote to Cox on the same day explaining that,

the Minister is quite definitely of the opinion that it would be most undesirable in the public interest for the Chief Medical Officer of the Ministry of Health to intervene in your litigation with the STAR newspaper. He sees very grave objection to my giving evidence....I trust you will not subpoena me against [his] wishes.

Soon thereafter Sir Donald MacAlister declined to give evidence on the grounds that as President of the GMC dealt with the BMA on judicial grounds and this would prejudice his statements, (it seems he was referring to the BMA being a complainant to the Council). Following this Sir Humphry Rolleston and Sir Norman Walker, both GMC members also declined to give evidence.

The Association took up Dawson’s recommendation, and allowed him to negotiate with the Star. He soon secured an agreement, and the Star published a statement of apology and retraction. The case was dropped and both sides waived any question of costs, which totalled £225 for the BMA. Although the BMA can be seen as acting to uphold gentlemanly behaviour in the profession it seems that members of the medical aristocracy were instrumental in preventing them from creating too much public fuss, seemingly ‘collapsing’ the case against the Star. Perhaps their instinct was to conceal the divided nature of not only the elite, but of the whole profession, preferring honourable private agreement to public conflict. Several of these men also made public or official moves which tended towards creating a consensus on the issue.

Lord Dawson had appealed for accuracy of content and dignity of style in signed articles Thomas Horder spoke to the St Pancras Division of the BMA in October 1927, a meeting to which representatives of the New Health Society and the Press were invited. In this address he steered a skilful rhetorical path, appearing enthusiastic about health education and generous about the New Health Society, whilst roundly condemning the practice of indirect advertising. George Newman helped stimulate BMA involvement in health education, through his 1925 Memorandum on the subject. In September 1926 the BMA had set up a

151 Transcript of telephone message, from Lord Dawson to Alfred Cox (Secretary of the BMA), 27.10.27, unnumbered folio, D108.

152 G. Newman, letter, 27.10.27, unnumbered folio, D108.

153 CEC Minutes 9.11.27, unnumbered folio, D106.


155 The Star, 1.10.26.

special sub-Committee to determine how the BMA could contribute to public health education. Like Horder, the BMA tried to dissociate health education from the particular style of article associated with Lane.

Only one further case of indirect advertising survives in the BMA archive sources. R F E Austin was referred to the GMC by the CEC in 1928 for publishing an article in *Health and Efficiency*. This is not to say that the issue had been resolved. Lane’s example along with those of his associates continued to be cited in defence of newspaper articles. He was never brought before the GMC by either the BMA, medical defence organisations, or the Royal Colleges. In the BMA’s case, the previous bad publicity and Lane’s continuing popularity with the Press were the reasons for this. In this light it is not insignificant that erasures from the register involving indirect advertising were almost invariably associated with unorthodox therapy or theory, usually naturopathy. Although the association between cases heard before the GMC and unorthodox medical views persists, one need not rely exclusively on an account of competing cosmologies, or of a concerted campaign here. Lane’s example may have meant that more than a simple case of indirect advertisement was needed to make the charge stick.

**Conclusions**

During the 1920s the BMA and GMC were frequently criticised by doctors and lay people in connection with the issue of ‘indirect methods of advertising’. The origin of these criticisms and the way in which the BMA and GMC responded to them can be understood in the context of the shift from the Victorian emphasis on gentlemanliness, to a more modern ideal of scientific public service. This outburst of discontent was not, in itself, a particularly important event, or turning point, but rather a point of tension during a long process of change.

The whole idea of a gentlemanly profession can be seen as increasingly problematic. Doctors might be members of the profession but not full members of the ‘club’. ‘Rank and file’ doctors looked to the BMA in particular to represent their interests and aspirations, and were often offended by the way in which the Association behaved towards them. The inconsistencies and contradictions in the BMA’s position were consequent on its attempt to represent a body of practitioners that was in reality deeply divided, and divided in increasingly complex ways. Perkin describes modern professional society as having ‘vertical’ ‘professional

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157 See CMAC, SA/BMA/D151.

158 The case was heard twice, at the first hearing (GMC Minutes, LXV, pp. 52 - 3 (28.5.28)). The case was adjourned for 12 months, and on resumption he was cautioned. (GMC Minutes, LXVI, pp. 11 - 12, (28.5.29)).

159 R. F. E. Austin, ‘Nature Cure Explained, The Truth about appendix operations’, *Health and Efficiency*, XXVI: pp.321 - 2. This piece damned the practice of appendicectomy and favoured naturopathy, and was connected in an editorial column with the death of actress Florence Mills after an appendicectomy. Austin was a retired RAMC officer.

160 See CMAC, SA/BMA/D151

161 See Brown, op. cit., note 129 above.

hierarchies”, whilst the former social order had been based on the “horizontal solidarities” of class. Here we see the problems of persisting “horizontal” class divisions within a profession that was modelling itself increasingly on a ‘vertical’ unity.

The elite seem to have thought of the protection and promotion of the profession as being, of itself, in the public interest. The public, through the press called for reform (particularly of the GMC) to break the medical monopoly on decisions and rules that were felt to influence public health. Although gentlemanliness was still an important quality in public life, a convincing demonstration of commitment to the ethos of public service seems to have been the key to winning public and government approval. The depth of criticism of the medical profession we have seen in the advertising controversy stemmed, in part, from the failure of the BMA and GMC to understand the importance of participating in this process publicly.

Doctors who were able to use the media for their own ends, be they altruistic or mercenary, were in a better position to set rhetorical arguments, and to avoid disciplinary proceedings, especially if they were either members of the “medical aristocracy”, or enjoyed their protection. Conversely, having failed to understand and secure public approval, the BMA on the one hand found itself unable to act against either against Lane or the Star, and the GMC on the other underwent a change in the purely medical membership it had enjoyed for 70 years. Both organisations were seen to be failing to “serve the people” be they humbler medical practitioners or the general populace. Their strategies for upholding the status of the profession were counter-productive because they were based in a pattern of power and behaviour that was being eclipsed. In other ways the echo of larger events is discernable in this controversy. Whilst the end of the Great War brought for many a return to ‘business as usual’ there was a significant tendency to distrust “The Old Men”, who were blamed for creating a holocaust for the sake of their pride and power, a distrust that was to become integral to modern thinking.  

The medical profession in the 1920’s was held in fragile esteem. It maintained a facade of dignity and unity which hid not only deep divisions and contradictions, but the contorted effort to keep it standing.

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