PART TWO

THE EIGHTEENTH-CENTURY PHILOSOPHICAL BACKGROUND

INTRODUCTION

Radically oversimplified, the tale we tell in these two volumes opens with an account (in the preceding section) of the moral disarray in eighteenth-century British medicine. Moral order, or, at least, a sense of workable standards of propriety, is restored at the end of the century by the almost universal acceptance of the writings of two physician-ethicists: John Gregory (1725–1773), whose influential *Lectures on the Duties and Qualifications of a Physician* was officially published in 1772; and Thomas Percival (1740–1804), whose most influential work, *Medical Ethics*, was published in 1803. The rest of the story unfolds in volume two, which relates how nineteenth-century American and British medical societies drafted codes of ethics modeled on Percival's; and how, in 1846, the first national medical society, the American Medical Association, made its first order of business the adoption of a code of ethics based on Gregory and Percival – setting a model for medical ethics which remains dominant until the mid-twentieth century.

Gregory and Percival, therefore, are the pivotal figures around whom the eighteenth-century story turns. They become pivotal because, by appealing to philosophical conceptions of virtue and moral sense, they provided answers to problems that vexed not only Beddoes, Bracken and Cleland, but most eighteenth-century practitioners – the problem of distinguishing themselves as practitioners of a "liberal profession" from mere purveyors of a trade; of distinguishing etiquette from ethics; of distinguishing scientific practitioners from quacks; and, most importantly, of finding a professional way of handling the fractious and often fratricidal disputes that threatened to destroy the lives of medical practitioners and institutions.

Anyone enamored of the myth of the Hippocratic footnote will find the

R. Baker, Dorothy Porter and Roy Porter (eds), The Codification of Medical Morality, 93–98.

concerns of eighteenth-century physicians puzzling, since the Hippocratic Oath provides a basis for resolving these issues. Yet mention of the Hippocratic corpus is conspicuously absent from the writings of Gregory and Percival. There is, to be sure, an occasional passage echoing Hippocratic ideas; thus at the beginning of his first lecture Gregory explains to his students that "[By] the *practice of medicine* ... I understand, the art of preserving health, of prolonging life, and of curing diseases." In the mind of a scholar the use of the term 'art' suggests Hippocratic influence, but Gregory himself seems unaware of this. He never makes an explicit allusion to the tradition, or mentions the name "Hippocrates" to his students. What is striking, as the authors note in the preceding section, is that no one in the eighteenth century seems to pay any heed at all to Hippocratic ethics.

If Gregory and Percival did not hark back to Hippocrates to find a medical ethic, where did they look? Only Percival is explicit about his sources of inspiration, citing a host of moral philosophers and religious moralists, and singling out for special attention two names, Reverend Thomas Gisborne (1758–1846) and John Gregory. Gregory himself is more reticent about acknowledging his sources of influence, but he makes use of the language and concepts associated with the philosophers of the Scottish Enlightenment – most notably David Hume (1711–1776) and Adam Smith (1723–1790).

More specifically, Gregory's lectures reflect the central tenet of Scottish moral sense theory, that morality is a function, not of actions and their consequences, but of motivation and character. In the first two lectures Gregory portrays the moral physician's relation to his patients as motivated by non-selfish, benevolent "sentiments," such as "humanity" and "sympathy." He characterizes "humanity" as "that sensibility of heart which makes us feel for the distresses of our fellow creatures, and which of a consequence, incites us to relieve them" ([1], p. 22). Sympathy is the sentiment which engages the humanity of the moral practitioner and makes it operational by "produc[ing] an anxious attention to a thousand little circumstances that may tend to relieve the patient" ([1], p. 22).

Although the ideal of the humanistic physician whose effectiveness derives as much from an empathic understanding of his patient (sympathy) as from medical science is commonplace today, it was alien to eighteenth-century British medicine prior to the publication of Gregory's lectures. Indeed, Gregory had to defend his conception of the humanistic physician against critics who are "callous to sentiments of

humanity [and] treat this sympathy with ridicule, and represent it either as hypocrisy or as the indication of a feeble mind" ([1], p. 24). The "rough and blustering manners" affected by physicians in their interactions with patients in his day (and evident in the practitioner-patient relationship displayed in the writings and doings of Beddoes, Bracken, and Cleland) are condemned by Gregory as "generally accompany[ing] a weak understanding and a mean soul, and are indeed frequently affected by men void of magnanimity and personal courage, in order to conceal their natural defects" ([1], p. 24).

By the turn of the century Gregory's conception of the humane and sympathetic physician was accepted as the norm, as is evident from the criticisms leveled at Henry Bracken by his biographer. "In the time of the Doctor ... it was too much the custom of the Faculty, when a patient's case was critical, or become hopeless, to foretell ... how he would go on, or how and when he would die, &c. To the display of this vain, and often cruel, kind of prescience he was greatly inclined ...".[1] This biographical note was published in 1804, over three decades after the publication of Gregory's *Lectures*. Reflecting the sensibilities of medicine post-Gregory, the biographer remarks that this was no longer medical practice owing to "our progress in feeling and refinement." The standard which measures progress in practitioner-patient relationships in terms of "refinement" of "feeling" towards patients, is Gregory's; and the observation that doctors have revised their practices to conform to this standard is thus a testament to his influence.

Gregory's contemporaries were inclined to accept his views on medical ethics not merely because of the persuasiveness of his arguments, but because his conception of medical practice offered solutions to problems that vexed them, especially the eminently practical riddle of distinguishing those elements of customary medical behavior that were truly ethics (which Gregory, using the language of moral sense theory, calls "natural propriety") from those which were merely matters of etiquette and decorum. Gregory held that physicians had fundamental moral duties towards their patients. "The principal duties a physician owes his patients," he argued were grounded in the moral sentiments of humanity, patience, attention, discretion, secrecy, honor, candor, sympathy and temperance. These, Gregory claims, create "obligation[s which are] immutable, the same in all ages and nations" ([1], p. 34).

As Mary Fissell points out Gregory's somewhat abstruse view that immutable "natural proprieties" are grounded in moral sentiments

provided doctors of the period with a practical test for distinguishing ethics from etiquette. Ethics rests on real moral sentiments. Etiquette, decorum, and manners are merely pretended sentiments. Thus, whereas obligations grounded in moral sentiment are real and immutable, those grounded in pretended sentiments do not create real moral duties towards patients. They are, to quote Gregory, "founded in caprice, fashion, and the customs of particular nations." So, reasons Gregory,

> There is no natural propriety in a physician's wearing one dress in preference to another ... indeed ... external formalities have been often used as snares to impose on the weakness and credulity of mankind; that, in general they have been most scrupulously adhered to by the most ignorant and forward of the profession ([1], pp. 53, 54).

Perhaps the most attractive feature of Gregory's conception of the doctor is that it offered a solution to another problem that exercised Beddoes, Bracken and their contemporaries – distinguishing medicine (as a "liberal profession") from quackery and the "sick trade." Merchants and other tradesmen engage in trade for profit, the very same motive which prompts quacks to engage in the sick trade. Gregory's humanistic physician, however, engages in medical practice from motives of humanity and sympathy, not profit. The humanistic physician, therefore, can be neither a tradesman nor a quack. Thus by making "sympathy" the operational basis of moral medicine, Gregory effectively elevates the practice of medicine to an "art," or, as Gregory tended to put the point, a "liberal profession."

Yet, Gregory reassured his students that even humanistic medicine can still promote the "private interests of its members."

> ... medicine may be considered either as an art the most beneficial and important to mankind, or as a trade by which a considerable body of men gain their subsistence .... I shall endeavour to set this matter in such a light as may shew that this system of conduct in a physician, which tends most to the advancement of his art, is such as will most effectually maintain the true dignity and honour of the profession, and even promote the private interest of ... its members ... ([1], p. 13).

Here again Gregory has recourse to the theory of moral sentiment to reconcile the practical concern of his students to earn a living with the lofty goal of serving the art – that is, of preserving health, prolonging life, and curing diseases. The humanistic practitioner "naturally engages the affections and confidence of a patient," making the patient not only more amenable to cure but also a more satisfied customer. Since sympathy is

"an attention which money can never purchase" ([1], p. 22), humanistic practitioners of the art enjoy a decisive competitive advantage over their trade-minded competitors. Even the most pragmatic student can thus appreciate that virtue will find external reward.

Gregory gave his lectures to medical students, not to philosophy students. Percival wrote for physicians, not for philosophers. Thus while both writers draw freely on the language and logic of moral sense, neither explains the theory to his readers. The relationship between their work and moral sense theory (which is explored in some detail in the next section of this book) will not be evident from a direct reading of their writings. One needs, in fact, a background in the moral sense theories of the Scottish and (as it turns out) of the German Enlightenment. This section of the book consists of two chapters, one by philosopher Tom Beauchamp, the other by medical historian, Johanna Geyer Kordesch, which review, the development of moral sense theories in the Scottish and German Enlightenments.

The rationale for a chapter on British moral sense theory, especially the theories of the Scots, is evident; it provides the background which allows readers to appreciate why it would be natural for Gregory to conceptualize morality in terms of moral sentiments. Less evident, perhaps, is the reason for including a review of the development of such theories in the German-speaking world. It is somewhat insular to limit ideas to physical terrain, especially since both Gregory and Percival completed their education on the continent at Leiden (or Leyden) – which is also the *alma mater* of Benjamin Rush (1745–1813) and other eighteenth century medical ethicists. More importantly, as Kordesch explains in Chapter Five, German medical ethics of the eighteenth century was a sophisticated virtue ethic, a theory of natural propriety evinced through moral sentiments, very much like the theory that Gregory was to espouse to his students. The idea of a medical ethic grounded in moral sentiments and notions of "natural propriety" could not have been alien to anyone educated in this environment. Thus while the moral sense theory that Gregory ultimately drew on when he gave his lectures may have been Scottish, the seeds of an idea of a distinct medical ethic grounded in moral sentiments may have been transplanted from German culture.

The word 'may' is used advisedly, for we do not know which lectures Gregory (or Percival) attended in Leiden, nor do we even know what was on offer. Yet the fact of propinquity is so striking that it would be odd if Gregory did not assimilate aspects of the German-language ideal of the

virtuous and sentimental physician – carrying back to Britain the germ of an idea which would sprout in the rich intellectual soil of the Scottish Enlightenment.

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NOTE

[1] David Harley, this volume Chapter Two, p. 68.

REFERENCE

1. John Gregory, *Lectures on the Duties and Qualifications of a Physician*, London, 1771; all references are to the American edition published by M. Carey & Son, Philadelphia, 1817, p. 22.