

John Gregory's medical ethics and the reform of medical practice in eighteenth-century Edinburgh

LB McCullough

Professor of Medicine and Medical Ethics, Centre for Medical Ethics and Health Policy, Baylor College of Medicine, Houston, Texas, USA

ABSTRACT John Gregory (1724–73) wrote the first modern, professional medical ethics in the English language, appearing as *Lectures on the Duties and Qualifications of a Physician* in 1772. This paper examines Gregory's medical ethics as a blend of modern methods of medical science and ethics with premodern ideas. The paper begins by situating Gregory's medical ethics in the context of both private medical practice and the care of patients at the Royal Infirmary of Edinburgh, focusing on the crisis of intellectual and moral trust that prompted Gregory to lecture and write on medical ethics. Drawing on the modern methods of Francis Bacon's philosophy of medicine, and David Hume's science of morals, Gregory bases his medical ethics on the complementary capacities of openness to conviction and sympathy. His moral exemplars of the virtues of candour, steadiness, and tenderness were women of learning and virtue, reflecting the premodern idea of chivalry in the life of service to the sick.

Correspondence to LB McCullough, Centre for Medical Ethics and Health Policy, Baylor College of Medicine, One Baylor Plaza Houston, Texas TX 77030, USA

tel. +713 (0)798 3505

fax. +713 (0)798 5678

e-mail mccullou@bcm.edu

KEYWORDS Candour, John Gregory (1724–73), medical ethics, medical profession, sympathy.

DECLARATION OF INTERESTS No conflict of interests declared.

INTRODUCTION

In the past two decades, historians of medicine, bioethicists, and historians of medical ethics, have come increasingly to appreciate the important place of John Gregory (1724–73) in the history of modern medical ethics.^{1–3} Like many of his contemporaries in science, medicine, agriculture, philosophy, literature, and the arts, Gregory understood himself to be part of the Scottish Enlightenment, in that he was self-consciously committed to the improvement and reform of social institutions and practices. Gregory's main contribution was to the scientific, clinical, and moral improvement of medicine – to reform medicine into a profession scientifically and ethically worthy of the name.³

In this paper, I will describe the main elements of Gregory's reform of medicine and its very interesting blend of both modern methods and premodern ideas. Gregory's reform was at once progressive, even radical, but also, in an important sense, conservative. Appreciating the complex nature of his accomplishment – his influence, arguably, lasts into our own time – helps us to appreciate how the concept of a profession, insofar as it appeals to pre-modern ideas, sits uncomfortably in modern democratic societies because it dissents from their egalitarianism.

THE MEDICAL SCENE IN EIGHTEENTH-CENTURY EDINBURGH

It is commonplace in debates in the USA about healthcare reform to propose that we should adopt marketplace solutions to such problems as lack of insurance for, and access to, healthcare. These claims are made largely innocent of the long history of marketplace medicine, which flourished in eighteenth-century Britain (and North America). There was then no licensure, no stable medical curriculum, no private third-party insurance, and no agencies of government to regulate the practice of medicine and the development and introduction of new drugs and devices. There were myriad practitioners, including university educated (to whatever extent) physicians, apprentice-trained surgeons and apothecaries, female midwives, and other irregulars. All of these were in fierce competition with each other and with the sick who routinely practiced self-physicking, using both informal means, such as shared prescriptions, and more formal means, such as William Buchan's guidebook, *Domestic Medicine*.⁴

This was a real market; an unregulated exchange of services and fees, with the well-to-do sometimes not paying their fees, and physicians suffering lost income as a consequence (about which there was much complaint by physicians). Failure to compete successfully in this marketplace had serious economic consequences,

including economic ruin. As a consequence, physicians and other practitioners did what they could to stand out. They adopted distinctive dress, speech, and manners. They advertised their secrets and nostrums, often in book form, and regularly attacked each other in pamphlets and broadsides, in a social practice known then as 'flyting.'

There was then no stable concept of health and disease, as we now have. (Ours is that health, disease and injury are the function of the complex biopsychosocial interaction of genes, proteins and the environment, i.e. molecular medicine.) Indeed, there seem to have been almost as many concepts of health and disease, and therefore remedies, as there were practitioners. Theory and practice were shaped largely, if not completely, by individual practitioners' self-interest.

In *Patient's Progress*, Dorothy and Roy Porter document how the sick experienced entrepreneurial medical practice as a crisis of intellectual and moral trust.⁵ The sick often doubted, with good reason, whether practitioners knew what they were doing. The sick were also often concerned that practitioners were motivated mainly by money. In the vernacular of the time, physicians and other practitioners were understood to be 'interested' men. In our vernacular, they were motivated by, and acted mainly on, their own economic self-interest.

It should not come as a surprise that being a physician did not enjoy the high and secure social status that it now does. Indeed, it was something that a gentleman, i.e. a man of breeding and financial independence, did not condescend to do. Practicing medicine was one among many professions and 'profession' was used to mean, simply, an occupation, i.e. a way to earn a living.

Eighteenth-century British medicine also involved the creation of a new delivery system, the infirmaries, some of them under royal charter; for example the Royal Infirmary of Edinburgh. These hospitals were established by trustees – wealthy aristocrats and, increasingly, businessmen – to provide free medical care to selected populations, mainly the trustees' employees. The infirmaries came to serve the worthy sick poor who worked the land, the fishing fleets, and the mills of eighteenth-century English and Scottish towns.

As Gunther Risse has documented, the trustees of these medical institutions created them from complex motives, including, on the part of the businessmen, using a major philanthropy to advance their own social and political standing.⁶ In order to achieve this goal, the infirmaries needed to be known for their success, measured then (and now) by low mortality rates. To achieve this goal, the trustees charged lay managers to screen the sick who sought admission, and to deny admission to those at high risk of dying, usually designated as having 'fever'. Friedrich Hoffmann's admonition to physicians, in his very influential early eighteenth-century text, *Medicus Politicus*,⁷ to leave off

the care of the dying out of prudential self-interest, became organisational policy. Once admitted, the worthy, but not deathly ill, sick poor encountered a regimented environment in which they were subjected to the power of managers, of the forerunners of modern nurses, and of the physicians, surgeons, and apothecaries who staffed the hospital, appointed to this unpaid position by the trustees. Physicians coveted appointment to the 'faculty,' because of the stamp of approval such an appointment conferred, thus creating competitive advantage in marketing oneself and one's services to the trustees and the other well-to-do sick.

RESPONDING TO A CRISIS OF INTELLECTUAL AND MORAL TRUST: WHAT MOTIVATED GREGORY TO TEACH AND WRITE MEDICAL ETHICS

Gregory became concerned about the power that the faculty wielded over the sick, who came from the lower social classes, with whom most physicians – and the medical students whom he taught – would have had little or no social intercourse.³ One example Gregory provides is of younger members of the faculty who, starting on the wards with new patients, would promptly declare them incurable.⁸ They did not do this for the Hoffmannian, prudential reason to withdraw, so that overmastering disease or injury could be blamed as the cause of death, rather than the physician. Instead, they did this in order to justify performing experiments on the 'inmates' of the Royal Infirmary of Edinburgh. Gregory saw this practice, correctly, as motivated by self-interest in the form of ambition to become known as a leading scientific light, thus adding (so these young physicians had good reason to think) to their marketability.

The worthy sick poor were like the wealthy sick in their intellectual and moral distrust of physicians. The worthy sick poor in the Royal Infirmary, however, were in another respect very much unlike the wealthy sick. The wealthy sick usually came from a higher social class than physicians and, by paying the piper and calling the tune, wielded the power of the purse over physicians. The sick poor experienced in the infirmaries a hierarchy of organisational power, including power wielded by physicians who, though usually of modest economic means themselves, nonetheless came from a higher social and political class than the worthy sick poor.

Gregory had two related concerns.³ First, physicians providing services to the wealthy sick were 'interested' men with, therefore, no ethics to guide them. Second, physicians at the Royal Infirmary of Edinburgh, where Gregory practiced and taught, had gained power over the sick, but had no ethics to guide them in the exercise of this new-found power. As a result, those already made vulnerable by sickness and poverty, now experienced vulnerability to power motivated largely, perhaps even solely, by self-interest. Gregory saw this lack of ethics as unacceptable, indeed as the chief obstacle to medicine becoming a profession in a sense more meaningful than a mere

occupation. He reached this judgment as an Enlightenment Scotsman committed to both Baconian scientific method and to moral sense philosophy; 'interested' physicians acting for their own sake and not for the sake of the sick, whether wealthy or worthy poor; violated Baconian method, thus willfully creating the crisis of intellectual trust, and violated fellow feeling, thus willfully creating the crisis of moral trust. Medicine was in obvious need of improvement and Gregory set out to reform it, using the new empirical methods of Baconian clinical science and practice⁹ and the science of morals and moral philosophy of David Hume.¹⁰ Gregory turned to both sources because they offered methods for reaching true beliefs about the world and morality and well argued judgments based on such beliefs.

GREGORY'S MEDICAL ETHICS

Gregory's self-conscious and thoroughgoing commitment to the scientific methods of Francis Bacon dated from his days as a medical student at the University of Edinburgh. Baconian method is designed to reduce, and ideally eliminate, bias introduced by self-interest in its various forms. For Bacon, the pursuit of dis-interested science will improve science and medicine and thus 'relieve man's estate.'⁹

'The whole plan laid down by L[ord] Bacon for prosecuting enquiries into nature has been applied in some measure to many branches of natural philosophy, tho not with the accuracy and fidelity proposed by its great Author.'¹¹

Gregory committed himself, at just 19 years of age, to prosecute such enquiries in medicine, because medicine could not be improved scientifically and clinically if it remained riddled with the bias introduced by self-interest. The Baconian foundations of Gregory's medical ethics are plain in his texts, the anonymously published *Observations on the Duties and Offices of a Physician, and on the Method of Prosecuting Enquiries in Philosophy of 1770*¹² and *Lectures on the Duties and Qualifications of a Physician*, published in his own name in 1772.¹³ Gregory exhorted his students to study Bacon. Following Bacon, Gregory appealed to the human capacity to be 'open to conviction.' This is the capacity of disciplined thought and judgment that requires one to be open to evidence from whatever source it comes and, when the evidence is reliable, to conform one's knowledge and judgment to it. The capacity to be open to conviction is to be expressed and cultivated in the intellectual virtue of candour. Candour became for Gregory the fundamental intellectual virtue of physicians as professionals, in the sense of committing oneself to being a scientifically competent clinician. Scientific competence requires the physician to conform clinical judgment and practice to 'experience', the careful observation of the results of natural and controlled experiments in clinical practice.

'I may reckon among the moral duties incumbent on a physician, that candour, which makes him open to

conviction, and ready to acknowledge and rectify his mistakes. An obstinate adherence to an unsuccessful method of treating a disease, must be owing to a high degree of self-conceit, and a belief of the infallibility of a system. This error is the more difficult to cure, as it generally proceeds from ignorance. True knowledge and clear discernment may lead one into the extreme of diffidence and humility; but are inconsistent with self-conceit. It sometimes happens too, that this obstinacy proceeds from a defect in the heart. Such physicians see that they are wrong; but are too proud to acknowledge their error, especially if it be pointed out to them by one of the profession. To this species of pride, a pride incompatible with true dignity and elevation of mind, have the lives of thousands been sacrificed.'^{13, 28-29}

Gregory completed the methodologic foundations for his medical ethics by appealing to the capacity for openness to the experience of others, especially the pain, distress, and suffering of the sick. There is no doubt that, in doing so in his medical ethics, Gregory appealed to that core principle of Scottish Enlightenment moral sense philosophy – sympathy. Lisbeth Haakonssen argued that Gregory takes his version of sympathy or humanity (Gregory followed the custom of using the two interchangeably) from the moral philosophy of his cousin, Thomas Reid.² After a careful examination of the manuscript materials of the Aberdeen Philosophical Society,¹⁴ whose members devoted many meetings to Hume's principle of sympathy, I am convinced that Gregory takes his account of sympathy from Hume and not Reid.³ Gregory held that there is a:

'... distinguishing principle of mankind ... that unites them into societies & attaches them to one another by sympathy and affection ... This principle is the source of the most heartfelt pleasure, which we ever taste. It does not appear to have any natural connexion with the understanding.'¹⁵

In the deliberations of the Society, Gregory considered and rejected the view advanced by his cousin, Thomas Reid, that sympathy is inadequate to motivate and regulate moral behaviour by itself. Instead, external sanctions are required to supplement sympathy. Gregory explicitly rejected the need for external sanctions; sympathy properly formed and functioning could motivate and regulate moral character and behaviour.³ Both Haakonssen's and my own interpretations, however, agree that Gregory used 'sympathy' and 'humanity' to name the capacity of human beings to be open to the experiences of other human beings and to be motivated by those experiences to respond routinely in support of others.

Gregory, I believe, adopted Hume's account of sympathy because it had been established on the basis of Baconian experience and was therefore true. I also believe that Gregory found in sympathy the moral antidote to self-interest, to 'interested' men.

On Hume's scientific account of sympathy, it is a causal principle. The causal process of sympathy involves a double relation of impressions and ideas. Hume regarded this as one of the main scientific discoveries that resulted from his 'attempt to introduce the experimental method of reasoning into moral subjects,' to quote the subtitle of his *A Treatise of Human Nature* of 1739.¹⁰ Hume's account went, roughly, as follows:

Impressions are the result of the physical impress of the world on our senses. Ideas are abstractions, concepts, that we then naturally form of our impressions, especially those that are repeated. When I observe someone else in pain, this involves a physical impression on my senses of seeing, hearing, and perhaps also smelling. As part of our intellectual physiology, I then automatically form the idea of that person being in pain. The next two steps are also automatic in human beings, unless they have become morally deformed by an excessive commitment to the pursuit and protection of one's own self-interest. The idea that I have formed of another person being in pain automatically leads to an idea of myself being in the same or similar pain. This idea then activates an impression in me of the same or similar pain. I then feel the pain of, or feel for, this other person. This four-step sequence of an impression related to an idea to an idea related to an impression involves a 'double relation' of impressions and ideas.

Hume employs a vivid clinical example to illustrate the principle of sympathy, i.e. a real, constitutive cause in us that activates fellow feeling.

'When I see the effects of passion in the voice and gesture of any person, my mind immediately passes from these effects to their causes, and forms such a lively idea of the passion, as is presently converted into the passion itself. In like manner, when I perceive the causes of any emotion, my mind is convey'd to the effects, and is actuated with a like emotion. Were I present at any of the more terrible operations of surgery [namely, amputations], 'tis certain, that even before it begun, the preparation of the instruments, the laying of the bandages in order, the heating of the irons, with all the signs of anxiety and concern in the patient and assistants, wou'd have a great effect upon my mind, and excite the strongest sentiments of pity and terror. No passion of another discovers itself immediately to the mind. We are only sensible of its causes or effects. From these we infer the passion: And consequently these give rise to our sympathy.'¹⁰

Hume and the Scottish moral sense scientists called sympathy a principle: an intrinsic, real, causal process or force in us. Such principles constitute our nature, making Hume, and his Baconian contemporaries, including Gregory, essentialists about human nature. No-one lacks the capacity for sympathy. However, eighteenth-century commentators, especially women writers such as Hester

Chapone¹⁶ and Elizabeth Montagu¹⁷ whom Gregory knew, were clear that two kinds of conditions could distort the workings of sympathy. The first kind of condition blunted the workings of sympathy and manifested itself in dissipation in women, and hard-heartedness in men. The second kind of condition allowed sympathy to do its work unregulated and manifested itself as hysteria in women, and hypochondria in men. Both conditions make us unsympathetic, either by under-responding or not responding to others and leaving them worse off, or by over-responding to others and leaving them worse off.

Gregory understood that to have normative value, i.e. to form our character and to guide our judgment and conduct, sympathy-based moral science and philosophy require exemplars of properly functioning sympathy. Indeed, Gregory understood this requirement better than Hume, who did not have much to say about it. This is striking because it is plain from the text of Hume's *Treatise* that the virtues of sympathy, such as tenderness,¹⁰ were feminine virtues and would have been recognised as such by Hume's contemporaries. Gregory corrected Hume's methodologic deficiency by appealing to women of learning and virtue as his moral exemplars. He did so on the basis of two women in his life, his own wife and especially his friend in London, Elizabeth Montagu of the Bluestocking Circle.¹⁷ Women of learning and virtue exercised sympathy properly regulated. They were thus, crucially, capable of asexual, intimate relationships with men, providing a model of an intimate, asexual relationship between a physician and a patient, especially a male physician and a female patient. Following Rosemary Tong's distinction between *feminist* ethics – which asserts women's rights as an antidote to oppression – and *feminine* ethics – which asserts that women are role models of the virtues that we should all cultivate,¹⁸ we can characterise Gregory's distinctive addition to Humean moral philosophy as feminine medical ethics. As such, Gregory's medical ethics does not fit an 'engineering' model of 'applied ethics' but makes a significant and distinctive contribution to the histories of ethics and medical ethics – the first modern, explicitly feminine virtue ethics.³

In his *Lectures*, Gregory set out his general account of sympathy, which he then deployed to consider a wide range of clinical topics (a list that essentially anticipated the entire agenda of clinical ethics save for organisational ethics).

'I come now to mention the moral qualities peculiarly required in the character of a physician. The chief of these is humanity; that sensibility of heart which makes us feel for the distresses of our fellow-creatures, and which, of consequence, incites us in the most powerful manner to relieve them. Sympathy produces an anxious attention to a thousand little circumstances that may tend to relieve the patient; an attention which money can never purchase: hence the inexpressible comfort of having a friend for a physician. Sympathy naturally

engages the affection and confidence of a patient, which, in many cases, is of the utmost consequence to his recovery. If the physician possesses gentleness of manners, and a compassionate heart, and what Shakespeare so emphatically calls “the milk of human kindness,” the patient feels his approach like that of a guardian angel ministering to his relief: while every visit of a physician who is unfeeling, and rough in his manners, makes his heart sink within him, as at the presence of one, who comes to pronounce his doom. Men of the most compassionate tempers, by being daily conversant with scenes of distress, acquire in process of time that composure and firmness of mind so necessary in the practice of physick. They can feel whatever is amiable in pity, without suffering it to enervate or unman them. Such physicians as are callous to sentiments of humanity, treat this sympathy with ridicule, and represent it either as hypocrisy, or as the indication of a feeble mind. That sympathy is often affected, I am afraid is true. But this affectation may be easily seen through. Real sympathy is never ostentatious; on the contrary, it rather strives to conceal itself. But, what most effectually detects this hypocrisy, is a physician's different manner of behaving to people in high and people in low life; to those who reward him handsomely, and those who have not the means to do it. A generous and elevated mind is even more shy in expressing sympathy with those of high rank, than with those in humbler life; being jealous of the unworthy construction so usually annexed to it. – The insinuation that a compassionate and feeling heart is commonly accompanied with a weak understanding and a feeble mind, is malignant and false. Experience demonstrates, that a gentle and humane temper, so far from being inconsistent with vigour of mind, is its usual attendant; and that rough and blustering manners generally accompany a weak understanding and a mean soul, and are indeed frequently affected by men void of magnanimity and personal courage, [‘in order’ added in errata] to conceal their natural defects.¹³

Candour involves a direct engagement with human biology, being open to knowledge of its workings (which knowledge, Gregory lamented, is more of effects than of causes directly). Sympathy, or humanity, involves a direct engagement with the plight of the sick, being open to their suffering. Candour and sympathy thus blunt self-interest and also turn the attention of the physician away from himself and to the sick person, and motivate the physician to respond to the clinical needs of the sick person as the physician's primary concern, thus transforming that sick individual into a patient. Gregory became the first figure in the history of medical ethics to use ‘patient’ regularly and he did so more often than he used ‘the sick’ (for the Latin, ‘*aegetus*’).

With experience-based discipline, physicians acquire the twin moral virtues of sympathy, tenderness and steadiness. Gregory's feminine medical ethics is evident throughout this

text. Lady Macbeth complained of and to her husband that he was too full of the milk of human kindness and then called on the gods to unsex her, so that she could abandon her obligations of human regard and thus be free to kill King Duncan. Physicians without the milk of human kindness prey on the sick and pronounce their doom. Gregory also defends his feminine ethics in this text, noting that it does not ‘enervate or unman’ those who live and practice by it. He closes with a ringing defence of his feminine medical ethics, turning the then-common critique of it on its head.

Gregory was also well aware of the then-current crisis of manners (which we still experience): the lack of confidence that one can infer from another's admirable demeanor to the presence of good character. He was well aware that sympathy could be put on – manners coaches were then available to teach medical students and physicians how to do so – and patients thus deceived about whom they should be willing to trust with their secrets, health, and lives. Gregory therefore provides his medical students and readers with two behavioural tests for the genuinely sympathetic physician. The first is that the sympathetic physician does his work, which involves non-trivial self-sacrifice, without ever calling attention to himself, confident that a life-long moral commitment to the life of service will be recognised by others and that one's subsequent good reputation will indeed be earned. The second is that the sympathetic physician treats the rich and poor alike. Inasmuch as Gregory had been appointed First Physician to His Majesty, the King, in Scotland, Gregory was telling his students and readers that he treated the sick poor in the Royal Infirmary in the same way as he treated King George and vice versa. Both behavioural tests remain reliable and therefore current for those of us involved in medical education to evaluate our trainees and ourselves.

GREGORY'S REFORM OF MEDICINE INTO A PROFESSION

By employing Baconian medical science and Baconian moral science, and by building a feminine professional medical ethics on their foundations, Gregory set out to make medicine a profession in its proper scientific and moral senses.³ Gregory invented two of the three components of the concept of the physician as a professional. First, the physician should be scientifically and clinically competent, by being open to conviction, i.e. basing clinical judgment on ‘experience.’ This was to be achieved by practicing medicine and conducting clinical research according to the discipline of the intellectual virtue of candour. In other words, physicians should commit to practicing medicine and conducting research to standards of intellectual excellence. We now call this evidence-based medicine, an intellectual and clinical commitment and discipline that Gregory anticipated by more than two centuries. Second, physicians should make their primary commitment the protection and promotion of the health-related interests of patients and

keep systematically secondary their own self-interests. Physicians should not become 'interested' men. They were to accomplish this goal by practicing as sympathy requires, expressed in, and regulated by, its twin moral virtues of tenderness and steadiness. In other words, physicians should commit to practicing medicine and conducting research to standards of moral excellence.

Gregory anticipated the third component of medicine as a profession, when he attacked the then regnant 'corporation spirit' of physicians, i.e. their willingness to give priority to their collective or guild interests over those of patients and the community. The English physician-ethicist and author of the first book entitled *Medical Ethics* in any language, Thomas Percival (1740–1804), made this third component explicit when he called for physicians to maintain and pass on to subsequent generations of physicians and patients medicine as a public trust, rather than a merchant guild.¹⁹

Gregory did not understand the intellectual and moral concept of medicine as a profession – no longer a mere occupation – to reflect the status quo. Instead, he aimed to reform medicine into a profession, by improving it both scientifically and morally, in what amounts to a systematic rejection of the entrepreneurial, 'interested' status quo. Gregory's reformist medical ethics made it a major contribution to the distinctive Scottish Enlightenment commitment to improve, by reforming, social institutions and practices.

Gregory's was a remarkably progressive concept of medicine. It also remains so. Ironically, although self-consciously, Gregory's medical ethics was also conservative, though not perhaps in the way that historians of medicine use this word to characterise medical ethics. Instead, by 'conservative', I mean that Gregory draws deeply on pre-modern ideas to create the modern concept of medicine as profession.

THE CONSERVATIVE NATURE OF MEDICAL ETHICS: THE ROLE IN IT OF PREMODERN IDEAS AND THEIR IMPLICATION FOR CONTEMPORARY MEDICAL ETHICS

Historians and sociologists of medicine sometimes characterise medical ethics as conservative. By this, they usually mean that medical ethics has sometimes in its history been used by physicians to create and possibly also to sustain privilege and power. Medical ethics is thus not really ethics at all, but something else, namely, merely etiquette, or the drive for monopolistic power disguised in the linguistic dress of ethics. Such criticisms have been made of Gregory and Percival.^{20, 21} Robert Baker²² and I³ have shown that these criticisms do not withstand close scrutiny. In any case, I mention them only to distinguish this sense of 'conservative' from another, more ethically interesting sense, in which Gregory was indeed a 'conservative' thinker.

I continue this reflection with a closer examination of Gregory's feminine ethics. Gregory understood (better than Hume) one of the central methodologic requirements of virtue-based moral philosophy – the need for moral exemplars. Gregory found his in women of learning and virtue. Gregory accepted the view of self-educated women of learning of his time that for women of means to spend their lives at cards, the opera, and balls involved a life at high risk for dissipation and thus moral deformation. In his posthumously published moral handbook for his daughters, *A Father's Legacy*, he cautions them against the life of such idle women who squandered their intellectual capacities.²³ Unlike Gregory's critic, Mary Wollstonecraft, contemporary feminists might find something to admire in this aspect of Gregory's thought.

However, and in sharp contrast to what contemporary feminists might now think, Gregory thought that the confinement of women to the home and social spheres, away from city life and especially commerce, conferred moral advantage on them. This is because, as a committed moral sense scientist and philosopher, he correctly judged city life and commerce to be morally dangerous, because they were based on the pursuit of interest, i.e., self-interest, above all else. The single-minded, excessive pursuit of self-interest, of course, creates a life wholly at odds with the virtues and way of life required by the proper exercise of one's sympathy. Gregory's concern about the pernicious influence of self-interest shaped his medical ethics at its foundations. Indeed, his *Lectures* begins with an attack on interested physicians who have made medicine into a trade.³ This is a problem to be solved by reforming medicine into a profession. Gregory went so far as to propose eliminating payment of physicians and restricting the ranks of the profession to those of independent means.

Surely one of the glories of the modern world is the emergence of commerce. 'Glories' is appropriate because, in commercial exchanges, one's family of origin or national origin or other pre-modern sources of individual identity no longer matter. Markets became great levellers and propelled the emergence of egalitarian political philosophy so essential to the creation and maintenance of modern democracies. Gregory did not see glory; he saw 'interested' men, i.e. purveyors of moral predation. In other words, he reacted against the modern world of city life and commerce and found in the principle of sympathy a scientifically established basis for doing so. Women of learning and virtue became for Gregory the moral exemplars of a way of life based on a pre-modern concept of a life of service to others who are subordinate to one's influence and power. This is the medieval concept of chivalry, which had all but disappeared from the Scotland into which Gregory was born and lived. He was able to link modern moral science to chivalry and its life of service to subordinates and thus bring it, a strikingly premodern idea, into modern professional medical ethics. The result was an enlightenment, reformist, and conservative medical ethics.

CONCLUSION

Gregory based his medical ethics on Baconian openness to conviction and its intellectual virtue of candour and Humean sympathy and its moral virtues of tenderness and steadiness. In doing so, he created a concept of medicine as a profession that had – and continues to have – considerable subsequent influence. Gregory, along with Percival, reformed medicine into a profession in its proper intellectual and moral sense. However, if I am right about the conservative nature of Gregory's accomplishment, his concept of medicine as a profession is not a modern, egalitarian idea but a pre-modern idea of a disciplined life of service to those subordinate to one's influence and power.

I conclude by standing with Gregory in the eighteenth century and making some observations on the peculiar world in which we live. Gregory's conservative medical ethics provides us with a critical vantage point on the everyday, and therefore invisible, assumptions about the role of professions in egalitarian societies. First, medicine as a profession exists in an uneasy relationship with egalitarian societies and, especially, with market-driven 'reforms' of the organisation and financing of medical care. The physician–patient relationship is not egalitarian or contractual, but a fiduciary obligation of service and protection in which physicians know more about what is in

our health-related interests, as a rule, than we their patients do. This is not an egalitarian concept; indeed, it is anti-egalitarian. From its vantage point, market 'reforms' will be anything but; they will be predatory on the medical profession. In this respect, markets are very far from being neutral mechanisms of exchange. Second, with its strong emphasis on individual autonomy and, in its postmodern incarnation, deep distrust of claims to intellectual and moral authority by physicians (or anyone else, for that matter), bioethics has de-professionalised medical ethics. Bioethics speaks of a patient–physician relationship, without appreciating that in the absence of a profession of medicine, there are no physicians and therefore no patients. There are only the sick and practitioners. Gregory would have us regard both market reform and bioethics (as usually practiced) as radical and morally unacceptable undoings of everything that he aimed to accomplish. We would, I think, be altogether correct to agree with him.

ACKNOWLEDGEMENT

This paper was first presented to the Eleventh Wellcome Trust Regional Forum on the History of Medicine in Edinburgh, Scotland, 8 October 2005. It was subsequently presented as the inaugural lecture of the Medical Humanities Lecture Series sponsored by the School of Humanities Rice University, Houston, Texas, on November 15 2005.

REFERENCES

- Baker R. The History of Medical Ethics. In: Bynum WF, Porter R (editors). *Companion Encyclopedia of the History of Medicine*. London: Routledge; 1993; 852–87.
- Haakonssen L. *Medicine and Morals in the Enlightenment: John Gregory, Thomas Percival and Benjamin Rush*. Amsterdam: Rodopi; 1997.
- McCullough LB. *John Gregory and the Invention of Professional Medical Ethics and the Profession of Medicine*. Dordrecht: Kluwer; 1998.
- Buchan W. *Domestic Medicine*. Edinburgh: Balfour, Auld & Smellie; 1769.
- Porter D, Porter R. *Patient's Progress: Doctors and Doctoring in Eighteenth-Century England*. Stanford: Stanford University Press; 1989.
- Risse GB. *Hospital Life in Enlightenment Scotland: Care and Teaching at the Royal Infirmary of Edinburgh*. Cambridge: Cambridge University Press; 1986.
- Hoffmann F. *Medicus Politicus, sive Regulae Prudentiae secundum quas Medicus Juvenis Studia sua et Vitae Rationem Dirigere Debet*. Geneva: Fratres de Tournes; 1749.
- Royal College of Physicians of Edinburgh. Clinical lectures by Dr Gregory 1771 and Dr Cullen 1772. MSS C36; 1771:9.
- Bacon F. New Organon. In: Spedding J, Ellis RL, Heath DD (editors). *The Works of Francis Bacon*. London: Longman; 1875; 39–248.
- Hume D. *A Treatise of Human Nature*. Norton DF, Norton MJ (editors). Oxford: Oxford University Press; 2000.
- Aberdeen University Library. Medical notes. MSS 2206/45; 1743:1.
- Gregory J. Observations on the Duties and Offices of a Physician, and on the Method of Prosecuting Enquiries in Philosophy. London: W Strahan and T Cadell; 1770. In: McCullough LB (editor). *John Gregory's Writings on Medical Ethics and Philosophy of Medicine*. Dordrecht: Kluwer; 1998; 89–159.
- Gregory J. Lectures on the Duties and Qualifications of a Physician. London: W Strahan and T Cadell; 1772. In: McCullough LB (editor). *John Gregory's Writings on Medical Ethics and Philosophy of Medicine*. Dordrecht: Kluwer; 1998; 161–245.
- Ulman HL. *Minutes of the Aberdeen Philosophical Society*. Aberdeen: Aberdeen University Press; 1990.
- Aberdeen University Library. MSS 3107/1/4; 1759:7.
- Chapone H. *Letters Addressed on the Improvement of the Mind, Addressed to a Lady*. Maine: Daniel Johnson; 1806.
- Myers SH. *The Bluestocking Circle: Women, Friendship, and the Life of the Mind in Eighteenth-Century England*. Oxford: Clarendon Press; 1990.
- Tong R. *Feminine and Feminist Medical Ethics*. California: Wadsworth; 1993.
- Percival T. *Medical Ethics, or a Code of Institutes and Precepts, Adapted to the Professional Conduct of Physicians and Surgeons*. London: Johnson and Bickerstaff; 1803.
- Berlant J. *Profession and Monopoly: A Study of Medicine in the United States and Great Britain*. Berkeley: University of California Press; 1975.
- Waddington I. *The Medical Profession in the Industrial Revolution*. Dublin: Gill & Macmillan; 1984.
- Baker RB. Deciphering Percival's Code. In: Baker R, Porter D, Porter D (editors). *The Codification of Medical Morality: Historical and Philosophical Studies of the Formalization of Western Medical Morality in the Eighteenth and Nineteenth Centuries: Volume I: Medical Ethics and Etiquette in the Eighteenth Century*. Dordrecht: Kluwer; 1993; 179–211.
- Gregory J. *A father's legacy to his daughters*. London: W Strahan and T Cadell; 1775.