HEALING POWERS;
AN EXAMINATION OF MEDICAL ETHICS, BENEVOLENT LIES, AND
THE DOCTOR-PATIENT RELATIONSHIP IN LATE EIGHTEENTH-CENTURY BRITAIN

Rosa Dale-Moore
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Medical ethics is an applied philosophy. It rests upon the back of medical practice, and relies on the doctor-patient relationship for practical use. Therefore, an understanding of that complex relationship between physician and patient is crucial to a deep interpretation of any codified medical ethics. The doctor-patient relationship during the eighteenth-century in Britain was influenced by many factors, including deep power and education imbalances between doctors and patients, as well as the use of that power by physicians over their patients. This paper will discuss foundational thought for the practice of medical ethics in the context of Dr. Thomas Percival, a physician in late eighteenth century Britain, and his work in which he introduced a code of medical ethics in an attempt to correct the imbalance of values used by physicians in their medical practices and to codify medical ethics as a practice in the Manchester Infirmary.

Dr. Percival's writing illuminates many aspects of common medical practice in Manchester during this time, including the procedure of benevolent lies, a technique which involved the choice of a physician to not inform patients of their conditions because doing so would harm them emotionally more than it would help them intellectually. The use of such deceptions between late eighteenth-century doctors and patients was indicative of the power structures between physician and patient in late eighteenth-century Britain, and stemmed from the educational background of many Scottish physicians, from inequalities of wealth and status between physicians and patients, and the related knowledge and power discrepancies inevitable in the doctor-patient relationship. Percival's book *Medical Ethics* attempted to control and codify the use of power by physicians over their patients in a way which was benevolent while remaining inside the power structures of eighteenth-century British society.

Medical Relationships in the Eighteenth Century

The work of an eighteenth-century physician focused on the connection of the patient to the doctor, and the doctor's relationship with his peers. Similarly, much of Dr. Percival's writing in *Medical Ethics* concentrates on interactions between doctors and patients and the professional fraternity and understanding that was expected for physicians. Percival's emphasis on the latter was likely an important part of the professionalization and codification of the medical field at the time. He writes, "The medical gentlemen of every charitable institution are in some degree responsible for, and the guardians of, the honour of each other."[1] To this sentiment is tied a loyalty to the profession and to each other, which physicians are supposed to act upon. In relation to physician relationships, both with other physicians and with patients, Percival writes on one of the main problems he sees in medicine,

> This branch of the profession has been charged with hardness of heart: And some of its members have formerly justified the stigma, by ridiculing all softness of manners; by assuming the contrary deportment; and by studiously banishing from their minds that sympathy, which they falsely supposed would be unsuitable to their character, and unfavorable to the practical exercise of their art.[2]

Percival's observations and recommendation concerning the physician's relationship to his peers and to patients speaks to both purposes of *Medical Ethics,* which was a dual guide for both medical ethics and medical law for physicians and surgeons of the Manchester Infirmary. Originally, the work was to be presented as more focused on philosophy of law, and Percival writes, "This work was originally entitled "Medical Jurisprudence"; but some friends having objected to the term Jurisprudence, it has been changed to Ethics."[3] Percival's usage of the term

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[1] Percival, 31
[2] Percival 125
[3] Percival 7

'Medical Ethics' is significant because there was previously not a term used to refer to works on ethics in medical practice.

While *Medical Ethics* related dually to interpersonal relationships between doctors and between patients and doctors, the patient-doctor relationship was not one of peers, but instead one which was carefully nested in a paternalistic environment. Embedded in Percival's focus on the relationship between the doctor and the patient was a paternalism that seems to have driven many arguments Percival wrote on in *Medical Ethics*, a paternalism that stemmed the societal standards of the gentleman class in England. The perspective from which Dr. Percival writes is important because he was an member of "a single, recognized, social elite" as a gentleman-physician, and held a substantial amount of power in British society.[4] *Medical Ethics* was written by a gentleman-physician, for his fellow gentleman-physicians, and so the sentiments expressed in the book not only dictate how physicians were told to act, but also are revealing of how a person of gentleman class, educated in medicine, believed the medical field in his time should operate.

For context in the world of eighteenth-century medicine, Edward Shorter's *Bedside Manners* gives a generalized description of the average eighteenth century doctors and their interactions with patients. He writes that doctors were usually rich gentlemen-class workers and the field was in the midst of moving past a method that Shorter calls 'heroic medicine', which involved very painful procedures for the patient, i.e. bleeding, purging, and other techniques, into a more educated and competent medical practice. The physicians working before the eighteenth century were educated with little-to-no patient interaction, and the education was not sufficient to

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[4] Veatch 70

treat and interact with patients with any amount of medical knowledge[5]. Additionally, Shorter

cites a lack of trust as the leading force behind the poorly executed interactions between doctor

and patient[6]. Patients expected treatment from physicians, and those physicians insisted the

treatment they administer would be satisfactory. However, when the patients did not recover

because the doctor's chosen treatment was ineffective, the patient assumed the doctor to be

useless and simply trying to acquire money and prestige and "medicine was held in such low

esteem that traditional patients preferred to dose themselves or to seek out an "alternative'

healer."[7] Shorter's work explores the disconnect between patients and doctors that contributed to

the culture of medical care in eighteenth century Britain, setting the scene for Dr. Thomas

Percival's *Medical Ethics*. The relationships between doctors and between doctor and patient that

Percival wrote about were placed in the society Shorter describes. The medical practices in that

society evidently lead to the issues which Dr. Percival observes and attempted to correct with the

efforts at codification of medical practice in *Medical Ethics.* In order to begin

professionalization, Percival pulled from his educational background, which heavily influenced

his beliefs about medical ethics, including his family, education, and background in philosophy.

A Gentleman Physician; Dr. Thomas Percival

Dr. Thomas Percival was born in 1740 in Warrington, England. His father was an

educated merchant, and his grandfather and uncle were both physicians classically trained in

philosophy.[8] Percival's family left the Church of England in the late 1750s to join the Unitarian

congregation, labeling Percival and his family Dissenters.[9] Percival began his medical education

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[5] Shorter, Edward. 1985. *Bedside Manners: The Troubled History of Doctors and Patients* p. 36
[6] Shorter 61
[7] Shorter 61
[8] Haakonssen, Lisbeth. *Medicine and Morals in the Enlightenment*. Rodopi, 1997. p 94
[9] Haakonssen 94

in 1761 at University of Edinburgh, as he could not attend the Royal College of Physicians in London because of his religious identity as a Unitarian.[10] He completed his degree in 1765 at Leyden, with a Doctorate in Medicine, and then moved to Manchester in 1767.[11] Percival spent the rest of his adult life in Manchester, England, working as a physician because of the large Unitarian community centered around the city of Manchester. His later work in medical ethics was influenced by his upbringing and education. As Lisbeth Haakonssen writes in *Medicine and Morals in the Enlightenment*, "Each state of his medical education provides us with a richer context in which to situate his ideas" and philosophical theories on health and the human condition which Dr. Percival learned in university contributed to his view on society, community, ethics, and medicine.[12] Dr. Percival continued to be an active member in the Dissenter community, and he regularly published works on medicine, philosophy, and ethics.

The ideas of general humanity, benevolence, and honor were at the center of all ethics in the eighteenth century, and Percival's medical ethics are no exception.[13] The influence of Scottish Enlightenment ethics and morality is evident in Percival's text. He writes that the factors of utmost importance in practicing moral medicine are attention, steadiness, humanity, secrecy, delicacy, discretion, fidelity, and honor, which indicates that Percival's upbringing, education, and society, all had a part in creating his interpretation of medical ethics.

The ethical views of a previous physician, Dr. John Gregory, align strongly with those of Dr. Percival. Gregory worked in Edinburgh just decades before Percival, and the two physicians have much in common, including their Scottish education and the publication of works on how

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[10] Haakonssen 108
[11] Haakonssen 109
[12] Haakonssen 96
[13] Haakonssen 100

physicians interact with their patients. For these reasons, the two are often connected in relation to the history of medical ethics. Haakonssen summarizes Baker's argument that Percival, "found his conceptual underpinnings in Gregory's idea of a moral sense that enabled people to judge behavior equally in any person, and that this led Percival towards a radical egalitarianism both between private patients and patients in the public hospital, and between practitioner and patient."[14] In relation to the publication *Medical Ethics,* the 'radical egalitarianism' is not that of equality, but more of a sympathetic and benevolent use of the power exerted by the physician. Percival and Gregory both carried the connotation of their education into their medical practice, linking them together with the Scottish Enlightenment. Haakonssen argues in agreement with Robert Baker that "it is a mistake to see a fundamental split between Gregory and Percival."[15] The link between John Gregory and Thomas Percival was more than just morals, in fact they are tied together by their education within the Scottish Enlightenment tradition of ethics.[16]

Humean Sympathy and Percival's *Medical Ethics*

As a result of their education in the Scottish Enlightenment, Percival and Gregory both studied works by eighteenth-century philosopher David Hume. The influence of Hume on Dr. Gregory, and subsequently Gregory's influence on Percival can be better understood through an explanation of the concept known as Humean sympathy as it pertains to the education of physicians in the Scottish Enlightenment. Hume believed that sympathy was part of human physiology, and directly that "Sympathy makes us feel the distress of the sick and moves us to relieve that distress."[17] In relation to medical ethics, Humean sympathy suggests that the distress

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[14] Haakonssen 10
[15] Haakonssen 11
[16] Haakonssen 11
[17] McCullough, *Hume's Influence* 379

that humans feel in response to another's pain governs our actions in response that pain.[18] John Gregory was educated at Edinburgh like Percival, but in the 1740s, and learned the principles of Humean sympathy from his professors in the context of anatomy and physiology.[19] Dr. Percival studied Gregory's work, and mentions in the Preface of *Medical Ethics* "the late Dr., Gregory, of Edinburgh though his excellent lectures are, doubtless, in the hands of most physicians, yet I am tempted to make a transcript from them, because I with the present important subject to be viewed in the several lights, in which it has been presented to the mind by different writers, of acknowledged probity, information, and judgment."[20] Percival goes on to quote Gregory for two more pages, which reveals the deep connection between the two physicians. Percival writes on his predecessor's importance to the development and defense of gentleman-physicians: "The late Dr. Gregory, of Edinburgh, anxious to support the honour of a profession which loved, and of which he was a distinguished ornament, very strenuously repels the charge, against it, of skepticism and infidelity."[21] Percival's reverence of Dr. Gregory's work very much cements not only the bond between those two physicians, but also a bond across the profession in Britain in the form of information and teaching of Scottish Enlightenment philosophies. Almost fifty years after Gregory studied and devoted his profession of medical education using Humean values, Thomas Percival reviewed Gregory's work carefully, and *Medical Ethics* was largely influenced by Gregory's writing on ethics, as well as benefitting from the philosophical influence of the educations of both physicians.[22]

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[18] McCullough, *Hume's Influence* 382
[19] McCullough, *Hume's Influence* 386
[20] Percival, 189
[21] Percival 189
[22] McCullough's *John Gregory's Medical Ethics and the Reform of Medical Practice in Eighteenth-Century Edinburgh*

The influence of an eighteenth century form of justice can be linked to Humean sympathy, as Dr. Gregory wrote "The sympathetic physician treats alike the highborn, private patient who pays him, and the low-born Infirmary patient."[23] Similarly, benevolence towards patients was important to Percival, who wrote on treating patients in a hospital that "To neglect or to sport with their feelings is cruelty; and every wound thus inflicted tends to produce a callousness of mind, a contempt of decorum, and an insensibility to modest and virtue."[24] For both Percival and Gregory, the doctor-patient relationship was defined by power wielded with benevolence and kindness, inside a framework of Humean sympathy.

To get a sense of how Humean sympathy influenced Percival in his medical philosophy, take into consideration the quote from Hume that "Sympathy is not itself a passion; it is not the passion of pity, nor of "compassion."[25] Instead of the twenty-first century conception of sympathetic feelings, the sympathy of the Enlightenment was a communicated passion which acquired its strength from a transfer of affections through proximity and interpersonal connections.[26] The mechanism of sympathy requires the use of comparison, which allows the production of passions by comparing two situations, such as a doctor and patient, or a royal and a peasant.[27] Hume's conception of sympathy acknowledged that there is an opposite of sympathy, a disinterested, anti-social emotion.[28] "By "sympathy" Hume does not mean the specific sentiments of pity or compassion or benevolence but rather the function of communicating any sort of passion at all, whether it be anger, pity, or sympathy, because these emotions require

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[23] McCullough, *Hume's Influence* 383
[24] Percival, 11
[25] Hume, David, and Michael P Levine. 2005. *A Treatise of Human Nature*.
[26] Morris, William Edward and Brown, Charlotte R., "David Hume"
[27] Morris, William Edward and Brown, Charlotte R., "David Hume"
[28] Schmitter, "17th and 18th Century Theories of Emotions"

interpersonal connection. Dr. Percival's study of Hume and the use of sympathy in *Medical Ethics*, therefore does not mean a necessarily compassionate doctor, or a necessarily pitied patient. Micheal Frazer writes in *The Enlightenment of Sympathy* "Hume most often uses the work 'sympathy' to refer to a specific faculty of emotional communication that he describes in some detail, but does not restrict himself to this technical use of the term."[29] The basis of Hume's explanation of sympathy is in the tendency of humans to experience similar passions "given our own susceptibility to the passions we see in others, a sufficiently vivid idea of these passions will naturally leads us to think about ourselves."[30] In this way, Percival's use of Humean sympathy is not a powerful physician who pities a patient, but a more egalitarian feeling of emotional connection and communication between doctor and patients, although these doctors and patients do have a substantial power structure which separates them.

Dr. Percival and his peers educated in Scottish Enlightenment medicine learned multiple theories of philosophy and sympathy which resulted in a mosaic of philosophical ideas in Percival's work. A contemporary to Hume, Adam Smith was a Scottish moralist in the late eighteenth century. Both Smith and Hume used the idea of 'sympathy', but Hume's definition of the concept was distinct from Smith's. Smith argues in section VII of *The Theory of Moral Sentiments* that there are two questions that play an important role in his theory of moral sentiments. The first references the nature of virtue or morality, and the second is about our natural moral instincts. Smith's virtue is similar to that in the Stoic tradition, which assumes "a measured indifference to the events of human life."[31] Smith distinguishes sympathy and compassion, or pity, in his 1759 *The Theory of the Moral Sentiments*. He writes, "Pity and compassion are words

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[29] Frazer 41
[30] Frazer 42
[31] Bradie 41

appropriated to signify our fellow-feeling with the sorrow of others, sympathy, though its meaning was, perhaps, originally the same, may now, however, without much impropriety, be made use of to denote our fellow-feeling with any passion whatever."[32] Essentially, pity and compassion are passions which can be felt, but sympathy is the experience of sharing any passion with another person. This definition of sympathy does not fit Percival's own 'sympathy' as well as Hume's, which is the expression of any sort of social and contagious feeling toward another.

While Dr. Percival studied both Hume and Smith at university, Hume's idea of sympathy appears to apply more to Percival's personal conception of the concept. Percival writes in *Medical Ethics* "the best character is that which is not swayed by temper of any kind, but alternately employs enterprise and caution, as each is useful to the particular purpose intended", which is cited in Percival's book as from Book I of Hume's *Essays*.[33] While this use of Hume is not directly related to his views on sympathy, Percival's choice to use Hume's words in his own work is pertinent to Percival's own view on his main philosophical influences and speaks to the intent behind the creation of *Medical Ethics*. That intent was to use Percival's own education in the philosophy of sympathy from works created as a product of the Scottish Enlightenment to publish a work which addressed the issues of non-benevolent doctor-patient relationships in the Manchester Infirmary.

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[32] Smith, 1759, p49
[33] Percival 152

Dr. Thomas Percival's Publication of *Medical Ethics (1803)*

Prior to Dr. Percival's publication of *Medical Ethics* in 1803, Britain's medical practices were mostly private, and were patronized primarily by wealthy patients. The hospital in which Dr. Percival spent most of his time as a professional physician, Manchester Infirmary, was an extremely influential "social institution", and committed much of its funds to creating a sense of community authority.[34] An institution of this size held a great deal of power over both physicians who worked inside and around the Infirmary and the patients who received treatment. Part of the community authority attributed to the Manchester Infirmary included commissioning Percival to write his *Discourse on Hospital Duties,* as well as *Medical Ethics.*[35] It was through this institutional tract that Dr. Percival's work was disseminated to all people working in the hospital as well as doctors working privately in the community.[36] The power of the Manchester Infirmary in the eighteenth century means that the source of medical care in the city Manchester was controlled, either by physicians worked for the Infirmary, or with private practitioners and who only used the Infirmary for some medical procedures.[37] Additionally, the monopoly over medicine held by the Manchester Infirmary, combined with the power imbalance between gentleman-physicians and non-wealthy and uneducated patients influenced the culture of control and paternalism in the medical field.

Before the publication of *Medical Ethics,* the Manchester Infirmary was using a document called the *Statua Moralia* for their medical decisions and practices. Percival wrote, "Statuta Moralia of the college of physicians, whatever merit or authority they posses, are not

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[34] Haakonssen 130
[35] Haakonssen 130
[36] Haakonssen 130
[37] Haakonssen 115

sufficiently comprehensive for the existing sphere of medical and chirurgical duty: And by the few regulations which they establish, they tacitly sanction the recommendation of a fuller and more adequate code of professional offices."[38] According to Dr. Percival, there were aspects of the *Statua Moralia* and the practices it promoted that he and the professionals working in the Manchester Infirmary considered inadequate and lacking in merit or authority. *Medical Ethics* both exposes and attempts to set guidelines to remedy many of the problems Dr. Percival felt were prevalent in the medical culture.

Percival's writings in *Medical Ethics* are primarily focused upon patient-doctor relationships, and how to most benevolently treat the patient. He writes "The feelings and emotions of the patients, under critical circumstances, require to be known and to be attended to, no less than the symptoms of their disease: thus, extreme timidity with respect to venesection contra-indicates its use in certain cases and constitutions."[39] As a professional physician, Dr. Percival's study of people and their lives very deeply affected him, and likely drove his commitment to his publication of *Medical Ethics, Or, a Code of Institutes and Precepts, Adapted to the Professional Conduct of Physicians and Surgeons: to Which is Added an Appendix; Containing a Discourse on Hospital Duties.* Central to his argument for ethical conduct in *Medical Ethics* is the concept of progress and duty of people in power, i.e. with money, to help those that were poor and as a result lower in the social strata.[40] According to David McCullough in *Hume's Influence on John Gregory and the History of Medical Ethics*, the rapid increase of power placed on the work of physicians and decrease of the wealth of the average patient as public hospitals sprouted up across Britain left doctors subject to the temptation of "misuse and

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[38] Percival 6
[39] Percival 28
[40] Haakonsen 116

abuse of power — e.g., declaring patients incurable before standard treatment had been

administered, so that experiments could be performed that the self-paying, well-to-do patient

would never permit — required reform."[41] Additionally, the professionalization of medicine was

hampered by the rampant use of 'quack medicine', or ineffective home remedies. Dr. Percival

writes, "The use of quack medicines should be discouraged by the Faculty, as disgraceful to the

Profession, injurious to health, and often destructive even of life."[42] As he expresses his

concerns, Percival presents professionalization and codification of medicine as solutions.

Percival argued in *Medical Ethics* that poverty was a feature of society which contributed

to sin, and should be remedied with benevolent medical care. He wrote on this concept, "of these

schemes of benevolence all classes of men may have equal occasion to participate the benefits;

for human nature itself become the mournful object of such institution."[43] Clearly recognizing

the huge variance in wealth between physicians and many hospitalized patients, Percival used his

novel theories in medical ethics to argue that physicians should fulfill their duty of benevolence

with no bias towards the rich, even though rich patients would likely be able to compensate their

physicians more highly than poor patients.[44]

Payment of physicians for Percival was dually a necessary part of the social contract

between patient and doctor, and an opportunity to insert professionalized medicine into society

through standardized fees. He wrote "For it is obvious that an average fee, as suited to the

general rank of patients, must be an inadequate gratuity from the rich, who often require

attendance not absolutely necessary."[45] Percival believed that medical care should be affordable,

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[41] McCullough, *Hume's Influence,* p. 378-379
[42] Percival 44
[43] Percival 26
[44] Haakonssen 116
[45] Percival 40

but on a sliding scale, so as to keep balanced the status quo of the class of gentlemen to which

physicians belonged. However, he remained aware that motivation, especially for newer

members of the gentleman-physician class could be less than benevolent, which speaks to his

awareness of the peer relationships of physicians and the important of widespread

professionalization of their work. On this, Percival wrote,

> To a young physician, it is of great importance to have clear and definite ideas of the ends
> of his profession; of the means for their attainment and of the comparative value and
> dignity of each. Wealth, rank, and independence, with all the benefits resulting from
> them, are the primary ends which he holds in view; and they are interesting, wise, and
> laudable. But knowledge, benevolence, and active virtue, the means to be adopted in their
> acquisition of still higher estimation.[46]

While it may seem that Percival is explaining the existence of an implied contract between

physician and patient because of the aspect of professionalization efforts in the *Medical Ethics,*

there is a deeper motivation for Percival's *Medical Ethics*, which he explains in the Preface as

"[to] enlarge the plan of [the author's] undertaking, and to frame a general system of Medical

Ethics; that the official conduct, and mutual intercourse of the faculty, might be regulated by

precise and acknowledged principles of urbanity and rectitude"[47]. This section of *Medical Ethics*

further illustrates the duality of the purpose within Dr. Percival's mission. On this development

of medicine as a profession as opposed to a business, Percival wrote,

> The practice of [medicine as a profession and as a business] are incompatible: that while
> the practice of medicine ought properly to be lucrative, it was first and foremost a
> professional office, not a business; that holders of this office were under an obligation to
> society to use scientific knowledge to alleviate human suffering; and that this obligation
> transcended obligations to hospital trustees, to patrons, and even one's own need to make
> a living.[48]

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[46] Percival 40
[47] Percival 3
[48] Pickstone, John. *Thomas Percival and the Production of Medical Ethics*

Dr. Percival argues through his publication of *Medical Ethics* that medicine is becoming a business, which causes a slew of problems that he endeavored to address in the book, including the misuse of physician's power over a patient, in a way which may not be benevolent because it was geared towards profit, instead of healing.

Dr. Percival largely focused on issues of authority, control, and social responsibility in *Medical Ethics,* likely because he recognized the massive amount of authority inherent in medicine and the possibility for misuse of that authority. He wrote that physicians should also recognize this authority and, "Hospital physicians and surgeons should minister to the sick, with due impressions of the importance of their office; reflecting that the ease, the health, and the lives of those committed to their charge depend on their skill, attention, and fidelity."[49] While Percival considered the feelings of patients important, he also wrote that patients must not posses the same power over health in the same manner as a physician should. discourages doctors from visiting patients excessively, because his "frequent attendance on the sick diminishes their reserve, and entitles him to their familiar confidence."[50] The confidence and authority of physicians over patients, Percival believed, was extremely important in the healing process. Yet he was concerned that the same power could be misused. Therefore, the goal of medical practice for Dr. Percival is the benevolent use of the power of physicians, and his concern for the misuse of that power drove many of his comments on the doctor-patient relationship.

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[49] Percival 9
[50] Percival 13

The control that a physician is expected to wield over the information received by their patients is very reflective of the role of the physician in all patient-doctor interactions. Dr. Percival wrote,

> A physician should not be forward to make gloomy prognostications because they savour empiricism, by magnifying the importance of his services in the treatment or cure of the disease. But he should not fail, on proper occasions, to give to the friends of the patient timely notice of danger, when it really occurs; and even to the patient himself, if absolutely necessary.[51]

In this telling quote, Dr. Percival reveals the concept of benevolent lies, and argues a physician should use his judgement when telling patients of their surely fatal illness. That only 'if absolutely necessary' should a physician disclose negative medical information, because to do so when the situation does not warrant full disclosure would cause real harm to the patient.

While in apparent opposition to twenty-first century standards of autonomy and informed consent, this concept of benevolent lies was detailed in *Medical Ethics* by Dr. Percival because, while he strove for benevolent treatment of his patient, he believed that knowledge of a patient's impending death would hurt more than it could ever help the patient. He wrote in the same section, "For the physician should be the minister of hope and comfort to the sick; that by such cordials to the drooping spirit, he may smooth the bed of death; revive expiring life; and counteract the depressing influence of those maladies."[52] Percival's belief that physicians both 'comfort the sick' as well as 'smooth the bed of death' implies a certain level of flexible benevolence, meaning that in some situations, giving a patient knowledge of their dire medical situation may cause harm, and is therefore not a benevolent action. Additionally, Dr. Percival's awareness of the power structures in place, between doctor and patient, informed this part of his

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[51] Percival 31
[52] Percival 32

Medical Ethics. The power of the physician in this case is not the issue that Dr. Percival worried about, rather it is the use of this power for benevolence toward the patient that becomes Percival's main thesis.

Truth-telling in medicine was quite a contested topic in the eighteenth-century. Many physicians, John Gregory and Thomas Percival included, touted 'benevolent lies' as the best practice for dealing with disclosing bad news to patients. As Sokol notes, physicians "considered deception to be morally justified when used in the patients best interest."[53] This view was eventually integrated into the American Medical Association's Code of Ethics, first developed in 1847, much like most of Percival's *Medical Ethics*. There was at least one religious viewpoint which argued in opposition to Percival and Gregory. Revered Thomas Gisbone (1758-1846) wrote that "On ground of conscience and on the observation that lies usually fail to convince patients anyway", it would be better to tell patients the truth, even if the truth is bleak.[54] Gisborne also argued that patients who are nearing death would instinctively feel it, as God drew them closer to the end of their lives. Therefore, it was better to simply tell the truth, for patients will see straight through the lie and then form a distrust in the physician because of his dishonesty.[55] According to Shorter, the doctor-patient relationship was greatly weakened by this type of dishonesty, and Gisborne pointed out that the benevolent goal of Percival's deception did not outweigh the possible detriments.[56]

Percival's response to Reverend Gisborne was also later used in a section in the AMA Code of Ethics: "The life of a sick person can be shortened not only by the acts, but also by the

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[53] Sokol, Daniel. *How the Doctor's Nose Has Shortened over Time; a Historical Overview of the Truth-Telling Debate in the Doctor-Patient Relationship*, p. 1
[54] Sokol 4
[55] Sokol 4
[56] Sokol 5

words or manner of a physician. It is, therefore, a sacred duty to avoid all things which have a

tendency to discourage the patient and to depress his spirits."[57] If the physician held so much

power over the patient, but the patient also feels that power discrepancy is being used for ill in

their interactions with the doctor, then there is created a problem of trust in the relationship

between that specific physician and patient.

Benevolent Deception, Then and Now

Walter Freidlander writes in *The Evolution of Informed Consent in American Medicine,*

"One of the most important aspects of the relationship between a physician and a patient is what

the physician tells, or does not tell, the patient."[58] This decision has been one that belongs solely

to the physician since Hippocrates in 300 B.C.E. In ancient Hippocratic medicine, philosopher-

physicians often wrote about how to inform patients about their medical problems. The goal of

Hippocratic medicine was "how to benefit the patient most", very similar to medicine in the

eighteenth-century, and even in the 21st century.[59] The ever-famous Hippocratic oath states that

"I will follow the method of treatment which I consider for the benefit of my patients**,** from

which many interpretations could spring.[60] Plato, writing in 360 B.C.E., used a class system to

differentiate how to treat patients. First, the slaves, who were "asked no questions, given no

information, and handed some medicine", and the "'free men', attended by free practitioners",

were treated with more respect and given more support.[61] Trust was very important in Plato's

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[57] Sokol 4
[58] Walter Friedlander, *The Evolution of Informed Consent in American Medicine* p. 498
[59] Freidlander 499
[60] Freidlander 499
[61] Freidlander 499

medicine, and the free patient was given time to trust their physician before they were forced into any treatment, which made them more likely to follow the physician's beneficent advice.[62] The construction of a doctor-patient as described in Plato's medicine seems to follow the same basic rules as eighteenth-century medicine, those of benevolence and trust inside a power structure.

In contrast, Dr. Percival wrote "Let this hospital be the theatre on which you display, with assiduous and persevering care, your science, skill, and humanity. And let the manner correspond with, and even heighten the measure of your benevolence", which illustrates that in the eighteenth century benevolence was still a goal of medicine, but the society and science surrounding medicine had obviously and drastically changed from the time of Plato and Hippocrates.[63] Despite the differences between ancient medicine and eighteenth-century medicine, benevolence drove the doctor-patient interactions, within a scaffold of power and society.

Percival's codification of medical ethics was, at the time, a very new concept, but it was based upon one which was very old. Prior to the terms 'medical ethics', 'autonomy', or 'informed consent', the doctor-patient relationship served as an umbrella term for many of these issues. Laurence McCullough writes in *The Legacy of Modern Anglo-American Medical Ethics: Correcting Some Misperceptions* that some aspects of the history of Anglo-American medical ethics in the eighteenth and nineteenth centuries are commonly not represented correctly, even in scholarly sources. First, historical medical ethics is "taken by some to be little more than a collection of essays on medical etiquette and thus devoid of serious content *qua medical*

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[62] Freidlander 499
[63] Percival 124-125

ethics."[64] There is a misconception by many sources, McCullough argues, that take ethics in medicine as simply "the appropriate color and style of a physician's dress or fee-splitting in consultations."[65] This paper argues in agreement with McCullough, that medical ethics in the late eighteenth century was more complex than just basic etiquette.

Along those same lines, the idea that gentleman-physicians in Britain were simply spouting the philosophies that they learned in school is flawed, according to McCullough.[66] Admittedly, there are similarities between concepts in Percival's *Medical Ethics* and common etiquette of the day. However, to focus on those aspects is to forget that physicians drew on many sources for their ethical inspiration. Among others, religion and philosophies, including those of the Scottish Enlightenment, contributed greatly to the creation of medical ethics in the late eighteenth-century.[67]

In modern medicine, there are different codes of ethics, specifically that of the American Medical Association which have followed Percival's writings in some sense. Bioethics is now a field of study, and the values of Western society have changed since the time of Dr. Percival. However, the concept of benevolence is still at the center of the doctor-patient relationship, even if the the act of benevolence has been redefined multiple times, and continues to change. The common thread of the doctor using situational judgment regarding the relationship between a lie and benevolence though medicine can be seen in Dr. Percival's concept of "benevolent lies", as

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[64] McCullough, Laurence, *The Legacy of Modern Anglo-American Medical Ethics: Correcting Some Misperceptions* p. 47
[65] McCullough, *The Legacy* 47
[66] McCullough, *The Legacy* 47
[67] McCullough, *the Legacy* 48

well as in some modern doctor-patient interactions. Marc Agronin, reporting for the Atlantic,

writes:

> Truthfulness is the foundation of the doctor-patient relationship, both as a method of discourse and as one of the "most widely praised character traits" of a doctor. Gone are the days when doctors withheld certain diagnoses or treatment details from patients. If anything, doctors today are often forced to disclose excess and sometimes unnecessary information due to concerns about liability or to patients who have already canvassed the Internet on their own and have pressing questions.[68]

 According to Agronin, there are situations in which a benevolent deception is the most

benevolent action towards the patient. He writes, "As much as I urge eventual, complete

disclosure of the truth to every patient, there are individuals with dementia who will not be able

to appreciate the meaning of what they are told and cannot correctly distinguish between truth

and deception. Perhaps there is still an obligation to at least go through the motions."[69]

The complete disclosure of medical information to every single patient appears to be the rote

line of any code of medical ethics in the 21st century. But the reality of medical practice tells a

different story. Agronin's article illuminates a more accurate representation of benevolent lies

that are told in North American hospitals and clinics everyday. He writes "Every clinician has

encountered situations in which being too bluntly honest about a diagnosis can actually be

harmful to the patient, and so we employ what is euphemistically referred to as 'benevolent

deception'."[70] This sentiment closely parallels to Percival's instruction that "A physician should

not be forward to make gloomy prognostications," nor should he tell a patient of danger if not

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[68] Agronin, 2011
[69] Agronin, 2011
[70] Agronin, 2011

"absolutely necessary."[71]The idea of intentionally hiding information from a patient in the name of benevolence has survived into the modern medical experience, in some cases. The power dynamics which drive modern doctor-patient interactions today are not as different from Percival's time as they might seem, although benevolent lies are no longer a outwardly spoken part of medical practice.

Bioethicist James Drane has another, less tolerant, view on modern benevolent lies. He writes "Determining the appropriateness of less than full disclosure is one thing, but trying to justify a blatant lie is another thing entirely. Lying and deception in the clinical context is just as bad as continued aggressive interventions to the end. Both qualify as torture."[72] The case Agronin discussed was very particular, that of a patient with dementia, so it is clear that benevolent lies as Percival knew them are not in common practice in modern Western medicine. However, the practice which Agronin describes supports the idea that despite changing legal and social values, a concept similar to Dr. Percival's practice of benevolent lies remains recognizable in contemporary Western medical practice, depending on the definitions 'absolutely necessary' disclosure of medical information.

Agronin's article focuses on one case, with one patient involved, which highlights some of the problems with analyzing medical ethics, both in the twenty-first and eighteenth centuries. While one of the limiting factors for studying medicine in the late eighteenth-century is the lack of surveys of "certain kinds of institutions, such as eighteenth-century infirmaries and dispensaries, other research has showcased the benefits of exploring health and medicine far

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[71] Percival 31
[72] Drane, Honesty in Medicine

beyond institutional settings."[73] Medical ethics is a huge topic to cover, and according to

Johnathan Andrews in his *History of Medicine: Health, Medicine and Disease in the Eighteenth*

Century , there is an extensive collection of patient records, but they are by large majority of

"elite patient perspectives."[74] The patient point of view in medical ethics remains a field that is

lacking in sources, despite "numerous deeper explorations of the wider social negotiation of

medical care, and of patient participation and expectations, in regard to health/medicine", which

makes the patient view an underdeveloped field.[75] In light of Andrews' observation on

availability of research on the patient view in the realm of eighteenth century medicine, it is

important to note that over half of the story concerning medical ethics is effectively missing or

skewed. On the contrary, the doctor's view is told time and time again in memoirs and codes of

ethics. Much more elusive is the point of view of the people not in power, which leaves an

unbalanced account. However, by analyzing the account of a gentleman-physician and his

thought on how medicine should operate as a profession, conclusions can be drawn about how

patients were being treated and cared for.

Conclusions

Dr. Thomas Percival felt that the medical practices in his community of eighteenth century

Manchester were failing the patients because of the opportunity for misuse of the power

bestowed upon the physician in his society. The doctor-patient relationship struggled as a result

of power and knowledge imbalances, lack of codified doctor-doctor relationships, the survival of

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[73] Andrews, Jonathan. *History of Medicine: Health, Medicine and Disease in the Eighteenth Century* p. 506
[74] Andrews 509
[75] Andrews 509

quack medicine into the late eighteenth century, as well as a lack of truly benevolent care from doctor to patient.

Through examining the philosophical, medical, and social lives of Dr. Percival in particular, the conclusions can be drawn that the power discrepancy between patient and doctor was concerning to Dr. Percival because of his education in and adherence to Humean sympathy and his experience in the Manchester medical community. He felt that patients were not being treated by their physicians with the utmost benevolence in mind. Dr. Percival's proposed solution to unethical medical practices culminated in the publishing of *Medical Ethics,* which outlines exactly how to fulfill the doctor-patient relationship ethically. However, Dr. Percival lived in society as a privileged gentleman-physician and held a great amount of power over his patients, as did his predecessors. The use of benevolent lies in medicine was integral to Percival's ideals of medical ethics because of these power structures as well as a commitment to benevolence. Dr. Percival's *Medical Ethics* codified and professionalized the practice of benevolent and ethical medicine and the decisions he made in the book and in his medical practice were colored by his experiences with doctor-doctor and doctor-patient relationship, his Scottish Enlightenment education, as well as his participation in the power discrepancy between doctor and patient which still exists today.

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