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THE CENTENARY OF THE GENERAL MEDICAL COUNCIL

BY

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The Medical Act of 1858 established as the chief agent of long overdue reform the General Council of Medical Education and Registration of the United Kingdom, referred to from its earliest days as the General Medical Council, a title officially adopted in 1951. The centenary of the Council's first session falls on November 23, a date which should be memorable in the annals of British medicine as marking the first practical step towards the united and well-organized profession of to-day.

Background of the Act of 1858

It is a curious paradox that a century dominated by the slogans of *laissez-faire* and rugged individualism should have produced legislation which regulates our life, both as individuals and as groups, in so many ways. It is another paradox that the decades of agitation for medical reform, carried on by enlightened medical men in the face of much public indifference, produced an Act to regulate and discipline the profession itself rather than to ban the activities of the thousands of untrained and irregular practitioners who battered on society. One historian of these events (Rivington, 1879) complained bitterly that this was done for the sake of the liberty of the subject, who should not be hindered in his choice of doctor, qualified or unqualified. "Freedom of choice" has a strange ring in such a context, but time has proved the wisdom of the Government of the day in promoting legislation for the profession rather than simple punitive measures against quacks.

The declared purpose of the Act was to enable the public to distinguish qualified from unqualified practitioners. In that same year Tennyson expressed the hope which inspired this declaration when he wrote, "We needs must love the highest when we see it." But what was the "highest"? When the profession quarrelled so openly about the status of the orders within its hierarchy the public could be excused for being bewildered. Until the General Medical Council was enabled, with the co-operation of the various examining and professional bodies, to undertake its difficult task of reformation—and at first it had to move very circumspectly—the nation was presented with the spectacle of a profession in chaos, unable to achieve order and agreement within its own ranks, split from top to bottom by jealous rivalries and competing interests, with all the ways to internal reform blocked by ancient privileges stubbornly preserved. The centuries-old division between physicians and surgeons and, later, the feud between physicians and apothecaries provide material for the more sombre chapters in the history of the profession in Britain.

A profession cannot be created by Acts of Parliament, as was proved by the first Medical Act of 1511-12, which was unenforceable for the simple reason that there were not enough regularly qualified physicians and surgeons in the country. With about one qualified man to 25,000 of the population the quacks were bound to flourish. For 350 years they often went scot-free while the licensing corporations wielded their powers—not wisely but too well—against men who had been regularly trained outside their ivory towers, the quality of such competition being much more dangerous. Without any support from the corporations which should have encouraged them the body of general practitioners developed from the humbler surgeons and the lowly apothecaries, originally mere compounders and dispensers of drugs. Men of ability and integrity by the standards of their own time, they were responsible for supplying the medical needs of the ordinary people up and down the country (see Bishop, 1952).

The Act of 1815, by which apothecaries gained the legal sanction to practise medicine, was the first triumph for the reforming spirit which was clearly at work among them even in the first decade of the nineteenth century. "Liberty, Equality, Fraternity" was the slogan of a nation with whom we were at war, but to many Englishmen it was none the worse for that. Less than 20 years later, in 1832, the very year of the great Reform Bill, the apothecaries banded themselves together for corporate action in the Provincial Medical and Surgical Association under the earnest and skilful leadership of Charles Hastings, of Worcester. One of the chief objects of the new association—which changed its name in 1855 to the British Medical Association—became clear in 1837, when a Medical Reform Committee was established. Before success crowned its efforts no fewer than 17 reforming Bills had been rejected by Parliament, most of them aborted by the refusal of other medical bodies to compromise with the spirit of the age.

What the reformers hoped to achieve by the Act was the purging from their ranks of unqualified practitioners, the removal of antiquated local prohibitions from the practice of regularly qualified practitioners, wherever they may have qualified, and a greater uniformity in qualifying examinations so that the graduates of "diploma mills," some of them little or no better than the quacks, could be gradually eliminated. Their ultimate purpose was to raise the status and attainments of the medical practitioner until he was worthy of the dignity of a noble profession.

But politics is the art of achieving the possible, and after its first enthusiastic reception the Act disappointed many of the most ardent reformers. Politicians and the

public generally were not ready to condemn the unqualified as totally beyond the pale, and the restrictions of legal registration to those qualified by examination was as far as they were prepared to go. In a brilliant memorandum on the subject to the General Board of Health John Simon (1869) pointed out that the Act would not achieve its object unless the "*legally qualified medical practitioner shall be a well-qualified practitioner.*"

The Council and its Functions

From its very beginning, then, the General Council was well aware that its chief duty was to establish and ensure proper educational standards for the profession. Its other duties were to compile and publish annually the register of qualified practitioners, admitting to it only the names of those whose education was deemed sufficient and removing from it, as occasion demanded, the names of those guilty of criminal offences or of serious professional misconduct. In addition, it was to be responsible for the publication of a national pharmacopoeia.

In essence, these duties were simple enough, but the powers of the Council were so vaguely indicated in the Act that every advance towards its goal had to be carefully prepared by long and sometimes heated discussions and by amending legislation. It faced this prospect in a manner which a later president characterized as tentative, hesitant, and half-unconscious (MacAlister, 1906). But if we recall certain historical facts we may understand better why this was so. Constitutionally, the Council was the first statutory tribunal of its kind with quasi-judicial powers over a whole profession. It is the nature of English law that it is developed by interpretation and precedent in the Courts, and until the Medical Act had been through this process its precise implications were unknown. Even the first members of the Council were in doubt about the nature of their corporate powers. The Council was not "our Medical Parliament," as even Sir Robert Christison, one of their number, called it in 1859 (Christison, 1886). Its legally defined purpose was to safeguard the public interest in certain ways and not to advance the welfare of the profession.

When put to the test the Act was found to be defective in many ways. The composition of the Council left the reformers in no doubt that it fell short of their demands, for the old corporations were present in strength while the profession at large had not a single direct representative. Nor did they consider that educational reform would be achieved very rapidly by a body which represented chiefly the existing and still fiercely competing licensing bodies. There were individual councillors for each of the nine medical corporations, for each of the four English and the two Irish universities, while the four Scottish universities had two between them, their number being completed by six Crown nominees and a president elected from outside their number. Only the nine corporation members were required by the Act to be registered medical practitioners; both the Crown and the universities could elect laymen.

Among the councillors who attended the first session in the Royal College of Physicians were some whose names are now part of our medical history: Acland, Christison, Clark, Corrigan, Green, Hastings (as a Crown nominee), Lawrence, Stokes, Syme, and Watson. On Acland's proposal, the beloved and widely respected Sir Benjamin Brodie, an old man of 75 already threatened with blindness, was elected the Council's first President. They set out to perform their duties as required by Parliament. Acland was so clear in his own mind about their nature that he had suggested that the Crown should appoint experienced and well-informed lay members of the House of Lords, such as Lord Shaftesbury, who would strengthen the administrative efficiency of the Council, correct its professional bias, and be in a position to promote measures of medical importance in Parliament. It is interesting to note that, clear-sighted as he was in most things, he did not anticipate the day when men who had

been raised to the peerage for their professional eminence and scientific distinction would sit as medical members of the Council. From 1926 onwards it was the practice for one of the five members nominated by the Crown to be a layman. The Act of 1950 increased the number of nominees to eight but laid down that three of them should be laymen.

Less than six weeks after its first meeting, the first issue of the *Medical Register* was due to be published. Thousands of applications were received in the last few days of December, and amending legislation had to defer publication until July, 1859. Taking the country as a whole, there was by now one medical practitioner for approximately 2,000 people, but only two in three were qualified. The first *Register* contained nearly 15,000 names, including some who, although unqualified, had been in practice in 1815 and were therefore allowed to register. Within 50 years the number grew to 40,000, and it enters its centenary year with a roll of 90,000.

Disciplinary Powers

The *Register* was welcomed by the reform movement as a valuable aid to its activities. Medical registration associations were formed on a local basis and prosecutions were brought against offenders, at first with disconcerting results, those who brought the charges being inadequately briefed on the loopholes in the law. This fact increased the disillusionment of general practitioners, who saw the Council merely as a private club for the powers of privilege from which they were excluded. True, they blamed the Council for not doing what it had no power to do, but in those first decades it was by no means a united club, and to some at least of its members "the inevitability of gradualness" was an attractive policy long before it was revealed to the Fabians. But there were too many forces at work for the overcautious to hold the reins for ever.

The clarification of the Act achieved in the courts gave the Council a clearer idea of its powers and responsibilities. A ruling from the Lord Chief Justice in 1863 stated that there was no legal appeal against the decisions of the Council and only one sentence possible if guilty—erasure from the *Register*. In 1894 came a progressive ruling which defined the phrase "Infamous conduct in a professional respect." This was interpreted as "that which could reasonably be regarded as disgraceful and dishonourable by [one's] professional brethren of good repute and competency." As ethical and educational standards have improved, the level of conduct likely to be so regarded has also been raised, so that many practices considered normal 50 years ago would not now be tolerated.

Reluctant as was the Council to censure or punish severely fellow members of the profession, it was carried along by the main stream of progressive opinion. Being uncertain of its powers to restore to the *Register* a name which had once been erased, it used its disciplinary powers hesitantly until a sound legal opinion in 1882 convinced it that a reformed offender could safely be reinstated, although in fact statutory power to do so was given only by the Medical Act of 1950. Reinforced by an ingenious system of probation based on a postponement of judgment for a fixed term, this new flexibility enabled the Council to act more energetically, and in the 1890's effective action was taken against such common abuses as canvassing for patients, the employment of unqualified assistants, and "covering" by association with unqualified and unregistered persons. Warning announcements were made in the medical journals of the day by the Council, and in 1905 these were given formal shape in the first Warning Notice. Enlarged and consolidated in 1914, this was printed in the *Register* of 1915 in much the same terms as those familiar until June, 1958, when a new Notice was drafted to incorporate other offences which have come more frequently to the notice of the Council in recent years. Until 1951 offenders were brought before the full Council, but the Act of 1950 sanctioned the appointment of a special Disciplinary Committee of 19 members as well as appeal to a court from its decisions.

The Struggle for Direct Representation

Apart from this gradual definition and moulding of the Council's character as a legal body there were important developments in the constitution of the Council which can be traced directly to constant and heavy pressure from the profession at large. On the passing of the Act of 1858 the Medical Reform Committee of the British Medical Association was reconstituted as the Committee on Medical Legislation, with the chief object of securing the election of direct representatives to the Council and the establishment of a "single portal of entry" to the profession, the lack of uniformity in the standards of the numerous licensing bodies offering too many opportunities for the entry of "licensed quacks" who could well be both illiterate and incompetent. There was also widespread discontent with the fact that many who were admitted to the *Register* possessed only "half qualifications" (in medicine or surgery only), but were legally entitled to engage in general practice requiring a knowledge of medicine and surgery and midwifery.

The Council gave a great deal of time and thought to this problem, and eventually sought amending legislation to rectify this last error; but, stimulated by the penetrating observations of John Simon at the Privy Council, a request was made that the Council should submit proposals which would remedy all the obvious defects of the Act. After lengthy discussions and complicated negotiations between the licensing bodies a miracle of agreement was achieved, for a plan was accepted which would set up three conjoint boards, one for each division of the United Kingdom, who would examine all candidates and grant a full basic medical qualification.

A new Act was drafted in 1870, but it made no provision for "direct representation" of the profession, chiefly, it seems, because Simon warned the Council that Parliament would never consider a Bill containing such a provision. The Association refused to support a Bill without it, with the result that the one in preparation was abandoned. The Council was so angered by this failure that five of its members, including Acland, Paget, and Stokes, who were all Vice-Presidents, resigned from the Association. Taken aback by this strong reaction, but undeterred by the immediate results of its insistence, the Association continued its campaign for another unrewarded decade, at the end of which a Royal Commission was appointed to investigate the complaints of the profession. The conclusions of its report, issued in 1882, recommended (1) a single portal of entry; (2) a reduction in the numbers of members of the General Council; (3) a large direct representation of the profession in the Council; and (4) that it be the duty of the Public Prosecutor to take action against unqualified practitioners. An ambitious amending Act embodying all these points was sponsored by the Government in the spring of 1882, but, although it was passed by the Lords, it did not reach its second reading in the Commons before the end of the session.

In the following four years other influences were at work and the Act of 1886 actually increased the number of members of the Council to 30, the licensing bodies each being given an individual representative and their number being increased by the inclusion of the Victoria University, which then incorporated the university colleges of Manchester, Liverpool, and Leeds. So much for the "single portal of entry." But the Act was a triumph for the reformers in that five "direct representatives," elected by all registered practitioners, were henceforth to sit on the Council, "as it was highly important that the Profession should have full and complete confidence in the Council."

On the occasion of the Council's jubilee in 1908 Sir William Turner recalled the difficulties of the passing of the Act of 1886 after committees, royal commissions, and governments alike had tried their hands upon its framing, and he paid a gratifying tribute to the influence of the direct representatives who came into being under that Act. On the same occasion Sir Walter Foster (afterwards Lord Ilkeston)

recalled that he had been one of the first direct representatives elected, and he claimed that their admission to the Council had exerted a great influence in raising and safeguarding the ethical standards of the profession, a fact recognized in gratifying terms by *The Times* in a leading article on the Council's Jubilee. Under the Act of 1950 the number of what are now officially termed "elected members" was increased to 11 in a Council of 47, including two for Scotland and one each for Ireland and Wales. In 1931, Sir Norman Walker, a direct representative elected by Scottish votes, became President of the Council.

Other Accomplishments

No historical sketch of legislation affecting the constitution and functions of the Council would be complete without mention of the Dentists' Act of 1878, which extended the registration—and consequent disciplinary—functions of the Council to dental practitioners. Working on the precedents already established in its regulation of the medical profession, the Council in effect created the dental profession from a body of tradesmen of whom only 483 (less than 10%) had any kind of qualification. When the Dental Board of the United Kingdom was established in 1921 it was able to take over from the Council the supervision of a profession whose education and ethical standards were rapidly approaching those already attained by their medical colleagues. Since 1956 dentists have had their own General Dental Council.

The Council was never involved directly in the controversy over the admission of women to the profession. If they were legally qualified then they had to be admitted to the *Register*, and, indeed, Elizabeth Blackwell was registered in 1859 by virtue of her medical degree from Geneva University in the State of New York. The Council had no medical women among its members until 1933.

Those engaged in practice in Britain but who had qualified abroad were entitled to registration under the Act of 1858. "Colonial" and foreign practitioners were allowed to apply for registration on a basis of reciprocity by the Act of 1886, and since that year more than 16,000 Commonwealth and foreign practitioners have been registered, there being more than 13,000 on the *Register* to-day. In recent years Commonwealth registrations have sometimes been more numerous than the total of Scottish and Irish registrations. Since 1947 temporary registration has been granted to sufficiently qualified practitioners from overseas who have secured hospital appointments in Britain, and the number of these temporary registrations now averages some 500 a year.

The Council's work for medical education and the *Pharmacopoeia* is discussed fully elsewhere in this issue. Much has been accomplished since Rivington justly complained in 1879 that "the least satisfactory part of the work of the Council has been given to professional education." Although the number of licensing bodies now existing and represented on the Council would have horrified those who spent years fighting for a "single portal of entry," we can now see that their relations with the Council and with each other have been transformed in the past 50 years—and in a way which we may regard as typically British. Persuasion, rather than compulsion, has been the chief instrument of reform, and a uniformity of standards has been achieved without sacrificing that variety and flexibility which is so necessary if initiative is not to be stifled. Public criticism and praise—for the Council's proceedings have been in public since 1864—have also been powerful in revealing faults and weaknesses and in illuminating good examples for others to follow. Only once, in 1895, has the Council been forced to take the extreme step of reporting to the Privy Council on the inadequacy of the diploma issued by a licensing body.

The development of a corporate spirit within the Council was not notable during the first half of its existence. Men of forceful character and strong opinions, as many of the early Council members were, often need the moderating

influence of a strong president. Fortunately for the subsequent developments of the Council's activities, such a president was found in Sir Donald MacAlister, whose term of office (1904-31), by far the longest of any President, must be accounted that which has had the greatest influence on the Council's history. Nobody to-day would claim that the Council is our "Medical Parliament." By the press and the public it is chiefly regarded as "our High Court." But that it has become a model of organization for other professions and other countries is sufficient tribute to its success in achieving two aims which the framers of the 1858 Act may have regarded as incompatible—the serving of the public interest and the advancement of the medical profession.

Many other books and articles, apart from those mentioned in the References, have also been consulted, but I am especially indebted for help and advice to Mr. Walter Pyke-Lees, Registrar of the Council, whose own booklet, *The Centenary of the General Medical Council*, is to be published by the Council on November 23, 1958.

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THE INFLUENCE OF THE GENERAL MEDICAL COUNCIL ON EDUCATION

BY

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The General Council of Medical Education and Registration was established by an Act of Parliament in 1858. Its principal purpose was to improve the education of doctors and create some semblance of order from contemporary chaos.

Nineteenth-century Background

At the beginning of the nineteenth century, as Dr. Charles Newman (1957) has pointed out in an admirable book, orthodox medicine in this country had reached a stable state in three orders—the physicians, the surgeons, and the apothecaries—and the chaos was largely but not entirely due to the fact that there was a fourth estate of unorthodox or empirical practitioners. How many totally untrained people practised as doctors before 1858 will never be known; early in the nineteenth century they were certainly numerous, and investigation in one English county reached the alarming conclusion that they outnumbered the qualified by nine to one. This county, however, was probably exceptional, because estimates based on the Census returns of 1841 suggested that only 5,000 of the 15,000 persons then practising in England were unqualified. In 1813 a Bill had been introduced in the House of Commons to put down empirical practice but failed to gain support—presumably because there was then no possible substitute for the numerous quacks.

The position may have improved somewhat with the establishment of private medical schools linked with the hospitals, but the committee appointed in 1834 to inquire into the state of the medical profession revealed a very unsatisfactory state of affairs when it published its evidence in the following year. Not only were the evils of quackery manifest, but also the inadequacy of

the training of many of the "qualified." Men, for instance, could take a degree in Arts, walk a hospital from three to six months, and immediately be licensed to practise as physicians. The academic course in medicine at the older universities must at that time have afforded ample opportunity for the use of leisure. Candidates had to be present at two dissections, "keep an act," and attend the lectures of the regius professor during three terms. It was found on inquiry, however, that in one university no regius professor had lectured for a hundred years, but degrees in medicine were nevertheless conferred. In Scotland, where the traditions of Boerhaave and Leyden were preserved, things were very much better.

Surgeons and apothecaries often served long apprenticeships and were probably more usefully equipped than physicians for the work they were to do—particularly when the apprentice was able to supplement his vocational training by a course at a private medical school. The conditions (and cost) of apprenticeships, however, were determined by negotiation between the parties concerned, and often the student might be little more than a menial servant.

Another factor that contributed to the general confusion was the number and diversity of the licensing bodies that had the right to confer professional titles. Before 1858 there were 21 such bodies (if the Archbishop of Canterbury be included), and the titles of most of them were valid in specific areas only (Heseltine, 1949): an Edinburgh licence, for instance, conferred no right to practise in London, and certainly none in Glasgow. As these bodies relied for their financial support on the fees they could extract from students, they at times embarked on dubious commercial competition: students, they found, could be tempted to enlist under the banner of an authority that would offer a cheaper licence and less severe examination.

Early Years

It is against this background that the influence of the General Medical Council must be judged a hundred years later. In its early years in the field of education the powers of the Council were very limited. It could require licensing bodies to supply it with particulars of their courses of study and examination; it could send visitors to examinations; and it could report to the Privy Council that in its judgment the courses and examinations were insufficient and should not confer a right to registration. Strangely enough, the Council had no power to insist on examinations in clinical subjects; neither could it refuse admission to the register to a candidate who had passed only a partial examination—in other words, a man could practise as a qualified and registered doctor if he had satisfied examiners either in medicine or in surgery. Twenty-eight years later this was remedied by the Medical Act of 1886, and the Council was enabled to secure the maintenance at final or qualifying examinations of a standard of proficiency "such as guarantees the possession of the knowledge and skill requisite for the efficient practice of Medicine, Surgery and Midwifery." It is a tribute to the influence of the Council that all licensing bodies had established clinical examinations many years before the Act of 1886 gave the Council power to insist on them (Pyke-Lees, 1958). Not until 1950 did the Council become entitled to inspect medical schools in order to determine whether the instruction given to students was satisfactory.

At its meetings in 1858 the Council decided there was urgent need for the improvement of the general education of students. That is not surprising. England has been dilatory in measures to provide general education for her young.