Routledge
Taylor & Francis Group

The Hippocratic Oath and Contemporary Medicine: Dialectic Between Past Ideals and Present Reality?

FABRICE JOTTERAND

Rice University, Houston, TX, USA

The Hippocratic Oath, the Hippocratic tradition, and Hippocratic ethics are widely invoked in the popular medical culture as conveying a direction to medical practice and the medical profession. This study critically addresses these invocations of Hippocratic guideposts, noting that reliance on the Hippocratic ethos and the Oath requires establishing

1. *what the Oath meant to its author, its original community of reception, and generally for ancient medicine,*
2. *what relationships contemporary invocations of the Oath and the tradition have to the original meaning of the Oath and its original reception,*
3. *what continuity exists and under what circumstances over the last two-and-a-half millenniums of medical-moral reflections,*
4. *what continuity there is in the meaning of professionalism from the time of Hippocrates to the 21ˢᵗ century, and*
5. *what social factors in particular have transformed the medical profession in particular countries.*

   This article argues that the resources for a better understanding of medical professionalism lie not in the Hippocratic Oath, tradition, or ethos in and of themselves. Rather, it must be found in a philosophy of medicine that explores the values internal to medicine, thus providing a medical-moral philosophy so as to be able to resist the deformation of medical professionalism by bioethics, biopolitics, and governmental regulation. The Oath, as well as Stephen H. Miles'

Address correspondence to: Fabrice Jotterand, MA, PhD(c) Senior Managing Editor, *The Journal of Medicine and Philosophy*, Rice University, 6100 Main Street, Houston, TX, 77005, USA. Email: fjotte@rice.edu

recent monograph, The Hippocratic Oath and the Ethics of Medicine, are employed as heuristics, so as to throw into better light the extent to which the Hippocratic Oath, tradition, and ethics can provide guidance and direction, as well as to show the necessity of taking seriously the need for a substantive philosophy of medicine.

Keywords: *Hippocratic Oath, Hippocratic tradition, philosophy of medicine, professional ethics*

I. INTRODUCTION

The Hippocratic Oath, the Hippocratic tradition, and Hippocratic ethics[1] are widely invoked in the popular medical culture as conveying a direction to medical practice and the medical profession. In particular, they have been invoked as a source of medical professional identity. However, closer examination shows more confusion than clarity. At best, one can say that the Hippocratic Oath, tradition, and mores have played a symbolic force as a moral rallying point at different times in the history of medicine.[2]

This study critically addresses these invocations of Hippocratic guideposts, noting that reliance on the Hippocratic ethos and the Oath requires establishing

1. what the Oath meant to its author, its original community of reception, and generally for ancient medicine,
2. what relationships contemporary invocations of the Oath and the tradition have to the original meaning of the Oath and its original reception,
3. what continuity exists and under what circumstances over the last two-and-a-half millenniums of medical-moral reflections,
4. what continuity there is in the meaning of professionalism from the time of Hippocrates to the 21st century, and
5. what social factors in particular have transformed the medical profession in particular countries (after all, it is far from clear whether there is one sense of medical professionalism shared by medical professionals across the world).

There is a challenge at the very outset: it is unclear what is meant by medical professionalism. Reflections in this area are at best unsystematic and underdeveloped. Many have argued that American medicine was in important ways deprofessionalized in the 20th century (Engelhardt, 2002a). This essay argues that the resources for a better understanding of medical professionalism lie not in the Hippocratic Oath, tradition, or ethos in and of themselves. Rather, it must be found in a philosophy of medicine that explores the values internal to medicine, thus providing a medical-moral

philosophy so as to be able to resist the deformation of medical profession-alism by bioethics, biopolitics, and governmental regulation. The Oath, as well as Stephen H. Miles' recent monograph, *The Hippocratic Oath and the Ethics of Medicine* (2004), are employed as heuristics, so as to throw into better light the extent to which the Hippocratic Oath, tradition, and ethics can provide guidance and direction, as well as to show the necessity of tak-ing seriously the need for a substantive philosophy of medicine.

II. HIPPOCRATIC MEDICINE

The extent to which the Oath has been, or still is, a basis for medical ethics is rather controversial and unclear. Some scholars, such R. M. Veatch (1988) or H. T. Engelhardt, Jr. (1986) for instance, either simply contend that the Hippocratic corpus as a sources of traditional morality for medicine is dead (Veatch) or point out that the Hippocratic ethic was limited to a particular group of neo-Pythagoreans and that to reconstruct a tradition relevant to contemporary medicine is rather problematic due to the lack moral agree-ment in society (Engelhardt). On the other hand, E. D. Pellegrino, (Pellegrino & Thomasma, 1981), maybe one of strongest proponents of the Hippocratic ethic, argues that the Hippocratic Oath is the foundation of Western medical ethics, which was, in his view, universalized in the early Middle Ages but needs, in contemporary culture, constant reevaluation.[3] Miles, as will see, proposes a mid-way solution (what he calls a "blended position") that appears to be attractive since it attempts to make strong connections between the Oath with current medical practice while recognizing that we live "in a world of contending and diverse moral systems" (Miles, 2004, p. 172). However, his interpretation of the Oath and its relevance to current medical practice remain at best *symbolic* (that is, in so far as one is willing to "*accept*" its ethical principles as ideals) which means that he is not able to provide strong arguments for a recognition of the Oath as normative for the medical profession as a whole.

Any appreciation of the place and influence of the Oath must be developed against a recognition that medical ethics and its ethos have been reshaped and transformed over the centuries. It is not simply the case that this ethics and ethos were recast by the Hellenistic age, Roman civilization, and Christianity,[4] as Miles acknowledges (Miles, 2004, p. 41). The contemporary appreciation of the ethics and ethos appears to as in the light of the Renaissance, the Enlightenment, and the emergence of post-modern reflections. It is very difficult to reach back and appreciate what that ethics and ethos meant to the Hippocratic community. It is as well necessary to recognize that there is not one ethics or ethos, but the meanings are plural over the centuries. The cardinal task of a philosophy of medicine is critically to locate the Hippocratic Oath and ethics within a

much more general appreciation of the nature of medicine and medical professionalism.

The tradition of Western medicine is often related to the person of Hippocrates (or the Hippocratic corpus), considered by some scholars as the founder of medicine as a discipline (Temkin, 1991, p. 42), and the "father of medicine" (Ackerknecht, 1982, p. 55). Furthermore, it is argued that Hippocratic writings, and especially the Hippocratic Oath,[5] have been the sources from which medical practice derives its principles of ethical conduct. Since the 1960s, however, medical practice has undergone a radical shift[6] from its original ideals (i.e., Hippocratic ethic, Percival, etc.) that appears in discontinuity with the old paradigm of medical practice, that is, what used to be called the "healing relationship" between the physician and the patient (Pellegrino & Thomasma, 1993, p. 104). In what follows, I consider the outcome of this radical shift in light of Miles exploration of the Oath in terms of the *identity* of the physicians, the *commitments* of the physicians, and medicine as a *profession*.

A. The Identity of the Physicians

Contemporary oaths taken by medical students will completely omit nearly two-thirds of the Hippocratic Oath.[7] The Oath or covenant begins by a lengthy invocation of the gods and goddesses. The next and most substantial section outlines the duties of the student to the teacher and the teacher's family, as well as the obligation to maintain the continuity of the transmittal of medical knowledge. Only then does the Oath turn to an outline of moral obligations. Even here, it must be noticed that the categories employed by the author of the Oath are not those of good and bad, moral and immoral. They focus indeed on but a sense of purity or holiness before the gods. The contemporary, moral reading of the Oath requires then a step away from an Oath that invokes categories of purity and rectitude before the gods in favor of an account better comprehensible in purely secular terms.

Last but not least, the Oath focuses on fashioning an esoteric esprit-de-corps. Nothing is to be divulged to the uninitiate. Here the Oath creates a professional identity that is not like that of the guilds of the Middle Ages authorized by a government in order to offer a sanctioned set of restraints on trade so as to maintain the quality of certain highly-valued services. The freestanding character of the medical profession in Hippocratic terms is underscored as well in "The Art," which says that "medicine is the only art which [the] states have made subject to no penalty save that of dishonour …" (Hippocrates, 1923c, p. 263).

Miles, it should be noted, anachronistically read the Hippocratic medical profession rather uncritically, as if it were straightforwardly a guild that provided the basis for an embryonic medical science that would eventually "form the foundation for the science and ethics of medicine" (Miles, 2004, p. 37).

Miles sees in the concept of a medical guild a positive emphasis on the wisdom of older physicians: first, older physicians know better the "speculative nature of medical innovations" and have learned how to put into practice what has been learned in the labs. In other words, they have a better understanding of the connection between theory and the clinical practice. Second, younger physicians are more likely to be tempted by the incentives proposed by representatives of pharmaceutical companies, which, in Miles' view, not only compromise the physicians' ability to practice medicine due to the biases of the material presented but also diminishes the patients' trust in the profession and in the educational institutions. In Miles' opinion, not enough attention has been given to reform or abolition of education by representatives of drug companies (Miles, 2004, p. 42–43). These are important issues that need careful attention but cannot be addressed in this paper. In short, Miles contends that this inter-generational dimension in medical practice reflects the moral obligation to consider one's teachers as one's parents and a way to secure the trust of patients and of public opinion.

B. The Commitments of the Physicians

The Oath rehearses a set of obligations that mix together both moral concerns and religious interests in purity. Striking also is the prohibition against surgery. This section of the Oath includes prohibitions against distributing poison to anyone, euthanasia, practicing abortion, performing surgery, having sexual relationships with patients, and divulging personal details of the patient's life or what was heard generally. Above all, however, the physician must restrain from all intentional wrong-doing and harm. Miles remarked that in Western modern societies physicians and health care professionals played a particular role in society which assumes a "special ethical 'contract' for their conduct," which is often expressed in the adage "*Primum non nocere*"[8] (Miles, 2004, pp. 50, 143). What the exact nature of this contract is and the basis for its obligatory dimension is not stipulated, nor clearly articulated by Miles. It is certainly the case that patients and society in general expect high standards of care for which the aim is the recovery and well-being of the patients. However, in our multicultural and pluralistic society it is difficult to produce a unique and coherent account of what, for instance, wrong-doing, beneficence or justice mean. Some physicians will see abortion as moral wrong in the majority of the cases while others will consider the abortion of a fetus resulting from rape as an act of courage. Likewise, the principle of justice is subject to many interpretations.

In fact, Miles interprets the vow to "keep the ill from injustice" as a particular commitment to a specific view of the good. He does this so as to develop a critique of the health care delivery system in United States in which "more than forty million Americans [who] do not have public or private health insurance for more than one year at a time, [a] fifth of these

are children" (Miles, 2004, pp. 59–60). This, Miles argues, is the result of an "unjust health care financing" part of a larger crisis of trust between the medical profession and society (Miles, 2004, p. 63). Miles, to strengthen his argument, refers to the opposition of the medical profession to the passage of Medicare in 1965 and to the lack of consensus among physicians to support the health care reform proposed by President Clinton during his first term (Miles, 2004, p. 60). While this is true that the medical profession is far from being united as to social concerns, particularly as to a universal health care system, it is worth noting that the introduction of the Medicare-Medicaid Act (1965–1966) during the Kennedy and Johnson administrations (1961–1969) is precisely the source of the dependence of medicine on social institutions, thus rendering it quite un-Hippocratic. The inauguration of the managed care era transformed the medical profession on two levels, one of them being the dependence on those institutions that are often criticized for limiting health care benefits.

The threat of malpractice lawsuits and the erosion of public trust in the medical profession due to the economic factors influencing health care delivery are important issues in contemporary reflections on the medical profession that "damage" to a certain extent the image of the medicine. Yet, the profound transformation of American medicine at the socio-economic level through which medicine became dependent on institutions (i.e., Health Maintenance Organizations, insurance companies, Medicare, Medicaid) and the industry for its viability cannot be ignored. A cogent criticism of contemporary medicine must take into account this crucial element which, as we will see, recast the idea of medicine as a profession.

Among others, Miles attempts a criticism of the American approach to the provision of health care resources by arguing that the Hippocratic Oath, as well as the Hippocratic tradition, imply an obligation to establish a universal health care. His arguments in these areas are underdeveloped and as already noted misleading. First, Miles argues from the Hippocratic injunction to keep the ill from injustice to an obligation in social justice. The Greek term *diké*, as used in the Hippocratic corpus and generally in Greek thought, had no implications of a claim regarding distributive justice. Rather, as Ludwig Edelstein remarks, the physician obligation is towards his patient and not society per se. As he writes, "the recommendation of justice epitomizes all duties of the physician *toward his patient* in the contacts of daily life, all he should do or say in the course of his practice; it gives the rules of medical deportment in a nutshell" (Edelstein, 1967, p. 37; emphasis mine). Second, from the fact of the matter that all industrialized societies except the United States provide for an all-encompassing health care system and also revere the Hippocratic tradition, it does not follow that they do so because of the Hippocratic tradition and its moral commitments. Third, and crucially, from the fact that the United States instead of securing a universal claim to health care provides a patchwork quilt of services, it does not follow that

the United States does not provide better care for most people, including the poor, than many of these industrialized countries.

Granted this is a complicated issue, but it is not one that Miles establishes convincingly, but which he is required to establish unless he wishes simply to hold that the establishment of a right to certain services without showing the actual benefit of that right is sufficient to secure his critique. Last but not least, he does not address the circumstance that all industrialized countries with universal health care coverage are more generally going a financial crisis and are as a result in the process of limiting their coverage and increasing the role of the private sector. This has particular relevance in that the Hippocratic Oath and Greek medicine were lodged in a market economy that eschewed governmental regulation of health care (on the concept of "civic physicians" in Ancient Greece see Nutton, 1992, esp. pp. 20–21; 1995, p. 37).[9]

Finally, one could argue that while it is certainly regrettable ("unjust" according to Miles) that some Americans do not have access to health care at a level higher that in many European countries, it must be emphasized that a universal health care system would likewise create injustice of various sorts. For instance, Canada prohibits already from buying better basic care, independently of one's ability to pay. The basis for a universal coverage and the notion of the right to health care seems then rather difficult to support. Not only does Miles fail to demonstrate how a universal coverage and the notion of the right to health care would be possible but he also did not recognize the politically charged tone of this arguments for a universal health care system. Curiously Miles ignores his political assumptions but is eager to stress that

> Today, all economically developed nations whose healers claim descent from the Hippocratic tradition view universal access to affordable health care as a moral obligation of their health care system—every developed nation except the United States. Many U.S. physicians argue that universal access to basic health care is about societal or political values that are external to medical ethics, and certainly outside the vision of the Oath. I believe that physicians could embrace a commitment to working for affordable universal health care as exemplifying the principle "from what is to their harm or injustice I will keep them." (Miles, 2004, p. 182)

Miles' interpretation of the Oath reflects deep social-political assumptions. His claim that "the legal and ethical norms for these [medical] activities and many other are governed by an implicit or explicit pact between physicians and society" (Miles, 2004, p. 50) is at best ambiguous if not simply biased by very particular conceptions of the good, the right and the just. The difficulty is that Miles does not develop the moral arguments needed to show that

1. a universal, state-endorsed right to health care is morally required as a response to the unfortunate circumstances of illness, disease, and insufficient personal resources. Nor that
2. such systems as they are in place in industrialized countries such as Canada, France, Germany, and the United Kingdom are able stably (given the financial pressure of social welfare states) over time to provide care better than generally available through the current American system.

Such may well be the case, but Miles does not provide the argument. Instead of a moral argument, he substitutes the dubious historical claim that the Hippocratic Oath and the professional tradition it supports requires such provision. To show this, one would need independently to establish that such obligations

1. are recognized by the Oath,
2. are justified by the Oath, and
3. should govern contemporary health care policy.

C. Medicine as a Profession

The Oath ends with the sanction that follows if the physician is not faithful of the covenant:

> If I fulfill this oath and do not violate it, may it be granted to me to enjoy life and art, being honored with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite to all this be my lot.[10]

Clearly, the Oath contains moral and ethical obligations, prohibitions, and exhortations that constitute the "profession's ideology" behind Hippocratic medicine. In ancient Greece, Miles comments, oaths have been called "connective tissue"[11] which "sealed political allegiances and united cults, guilds, and brotherhoods" and gave the social character of such institutions. Oaths imply not only the requirement to keep personal promises but likewise are "a social institution" which establish the rules for social interaction between individuals (i.e., physicians and patients in our analysis) who expect fidelity to the oath (Miles, 2004, p. 163).

Many scholars, Miles included, recognize that a position supporting the view that certain values and obligations are intrinsic to the practice of medicine (called "the internal morality of medicine")[12] is problematic due the various moral visions inherent of our pluralistic society. Miles adopts a middle way position arguing that the Oath reflects a "blended position in which society's time-tested moral views are the proper measure of the ethics of medicine" (Miles, 2004, p. 165). Thus, Miles accepts that the moral standards

of medicine must be reevaluated in the light the historical development of society but likewise suggests that the Oath ought not to be regarded as an old relic relevant for past medical practitioners of Ancient Greece. The Oath, he claims, can still teach us one medical ethic among competing moral systems. It is only insofar as one is able to understand (thus, the necessity to study the Oath) how the Oath might have spoken to its own culture that one will be able to see how relevant it is for his or her own. As he puts it, "Oaths do not compel ethical behavior, but they are human instruments that are crafted to sensitize the reader to moral moments and choices" (Miles, 2004, p. 172).[13]

This begs the question as to know whether everyone will recognize the moral values and obligations described in the Oath as relevant for contemporary medicine.

As I have emphasized, scholars such as Miles who regard the Hippocratic Oath simply as symbolic discount the full force of its power as a document to direct professional conduct. Thus although Greek medicine recognized and emphasized the idea of a guild/profession, it appears that it does not correspond to today's model of medical practice. Nutton explicitly remarks that

> The image of the Hippocratic gentleman is no more, replaced, at least in Britain and the USA, by that of the harassed general practitioner, the white-coated scientist, or the extravagantly paid, insurance-funded businessman. Gone too are the simple certainties of an ethic based entirely on what the doctor thinks is good for the patient, and with it also any acquaintance with Hippocratic morality outside the Oath and a few phrases such as primum non nocere … Professors of medical history are giving way to medical ethicists as the keepers of the medical conscience, or are themselves turning to history of ethics as a way to ensure the relevance of their own discipline in a modern medical school. (Nutton, 1997, p. 43)

As a consequence, Miles' attempt to make the Oath relevant to contemporary medicine remains ambiguous for two main reasons: first, the structure of our society simply does not allow the recognition of one grand narrative (Hippocratic tradition) able to sustain a profession, and second the idea itself of medicine as a profession (presupposing a particular set of moral values and obligations) has become problematic, at least in the sense of guild, for reasons I will develop very shortly.

That being said, rather than emphasizing on the Hippocratic tradition, or bioethics and biopolitics as a matter of fact, as the basis for medical practice and ethics, I argue that a reconsideration of the philosophy of medicine is necessary in order to preserve the moral foundation of medicine.

III. THE DEPROFESSIONALIZATION OF AMERICAN MEDICINE

To understand why moral reflection on medical practice moved outside medicine, thereby limiting the relevance of the Hippocratic tradition, it is important to examine how the deprofessionalization of medicine occurred in United States. The reasons are multiple and they deserve a more careful examination than what I will be able to accomplish in this article. However, it is crucial to locate the development of medicine in its proper context, particularly how American medicine went from the status of guild power between 1930 and 1965 to its decline in power from 1970 to 1990 (Krause, 1996).

Elliott Krause, in his book, *Death of the Guild,* argues that the loss of the guild power of the medical profession in the United States is principally due to the interaction of the medical profession with the state and capitalism (Krause, 1996, p. 44).[14] Prior to the loss of guild power, American medicine, through the AMA, effectively managed to control not only its professional identity but likewise to use its influence on the state and federal levels to secure monopoly powers, particularly in *education* (standards, accreditation) and in the *workplace* (hospital ruled by physicians).

The turning point, Krause argued, is the introduction of the Medicare-Medicaid Act (1965–1966) during the Kennedy and Johnson administrations (1961–1969). These two programs forced the federal government, through Congress, to seek to control the increasing costs of health care. Despite the protest of the AMA against what some perceived as "socialized medicine" (Krause, 1996, p. 43), the era of managed care was inaugurated early in the 1970s[15] with at least one major consequence: the nature of medical practice was profoundly altered on two levels. First, the medical profession could not maintain the independent professional and moral identity necessary to sustain a particular tradition, that is, the Hippocratic tradition. The reflection on the moral dimension of medical practice came to occur mostly outside the medical profession as bioethics gained respectability as an academic field. Second, a new set of socio-economic factors transformed American medicine in ways that modified not only the role of the physician in his or her relationship with the patient, but also how medicine became dependent on social institutions for its economic viability (Engelhardt, 2002a, p. 100). Cost containment appeared suddenly as a "moral obligation" imposed on the physician. This means that the physicians are no longer exclusively committed to their patients but also dependent on and controlled by the social institutions that structure health care, in particular its economic aspects.

These two factors contributed to the deprofessionalisation and the transformation of medicine into a vast industry, in which physicians lost their authority as professionals and became dependent on managed care organizations for their economic survival.[16]

A. Current Efforts to Reconsider Medical Professionalism

Some critics see in this transformation of medicine (Miles included, see for instance p. 182) a worrisome move away from the traditional commitments to patients as well as to the nature and values of medical professionalism. In response to these concerns, various efforts to reconsider and examine the concept of medical professionalism have taken place. One of them, which is the result of the collaboration of various medical societies (the American College of Physicians (ACP), the American Society of Internal Medicine (ASIM); the American Board of Internal Medicine (ABIM); and the European Federation of Internal Medicine (see Johansen, 2002), resulted in the publication of *The Charter on Medical Professionalism*. Interestingly and in relation to Miles analysis of the Hippocratic Oath, Jay Johansen wonders whether such a charter on medical professionalism will replace the Hippocratic Oath (Johansen, 2002). It is too early to say at this stage, but, as occurred when the Hippocratic Oath was formulated, the charter's publication is an attempt to (re)affirm some of the fundamental principles necessary for the practice of medicine.

This document (*The Charter on Medical Professionalism*) calls for a "renewed sense of professionalism" and responds to physicians frustrated by how health care is provided in society, which, it is argued, "threaten the very nature and values of medical professionalism."[17] This charter is supposed to ensure that all medical professionals and the health care systems are committed to the patient welfare and to "the basic tenets of social justice" (Johansen, 2002).

As is the case for the Hippocratic tradition, it is difficult to assess to what extent this charter built on the "moral traditions of physicians" has current moral significance for the medical profession. One of the main problems is that the terminology of the document appears too vague and imprecise to count as a "medical morality" for the medical profession. In light of the plurality of moral visions shaping the contemporary culture, the three fundamental principles of the charter (*primacy of patient welfare*, *patient autonomy*, and *social justice*) are subject to many interpretations and conclusions.

What is clear is that the Hippocratic tradition and its concept of medical guild and the concept of medical professionalism (as defined by the *Charter on Medical Professionalism*) cannot secure a coherent medical morality. In what follows, I argue that without further reflections in the philosophy of medicine the principles as described in the Hippocratic Oath (beneficence, justice, truth) and the *Charter* (autonomy, justice, patient welfare) will remain ambiguous and without substance. As David Thomasma asserts, a moral philosophy of medicine must be linked to a philosophy of medicine in order to provide the foundation of the medical profession (Thomasma, 1997, p. 128).

B. Rethinking Medical Professionalism

The question is whether the values and norms necessary to sustain the prac-
tice of medicine as a profession lie outside medicine or whether medicine,
by its very nature, involves certain inherent sets of moral and professional
commitments. So far, and contrary to Miles' analysis, my analysis seems to
suggest the former, that is, contemporary medicine is predominantly depen-
dent on socio-economic criteria external to the traditional set of norms and
values internal to medical professionalism. The dependence of physicians
on social institutions for the delivery of health care has created a new
paradigm in which physicians have a social obligation to respect cost
containment policies, which sometimes affect the welfare of the patients.
Miles obscures this new social obligation to respect cost containment as he
one-sidedly stresses that the social role of physicians is to be the stewards
of resources, a necessary condition, in his view, "to achieve just access to
health care" (Miles, 2004, p. 182).

Furthermore, the rise in power of bioethics and of bioethicists as
"moral expects" reflects the crisis in the moral identity of the medical pro-
fession, while creating suspicion in society, due to the uncertainty of the
moral character of medicine.[18] Not surprisingly, as the field of bioethics has
rapidly become one the principal sources of medical morality (consequently
marginalizing traditional sources of moral guidance such as the Hippocratic
Oath), the medical profession within a short period of time (more or less 30
years) has lost its social status and, to a certain extent, its credibility as a
profession more than any other profession (Krause, 1996, p. 36). Therefore,
to talk about medicine as a profession in the traditional sense (that is, as
self-regulating while possessing an internal code of ethics, particular knowl-
edge, and its own social dimension)[19] has become problematic since some
of the accepted characteristics of a profession have been questioned or
simply dismissed. In short, medicine has been deprofessionalized and
transformed according to a new set of socio-economic factors.

BEYOND BIOETHICS: RECONSIDERING A MORAL PHILOSOPHY OF MEDICINE

That being said, we must ask whether this transformation of medicine is a
positive development. The tendency of current bioethical reflection to move
from ethical reflection to legal and economic concerns (bio-politics) has
proven insufficient to sustain the moral identity of the medical profession.
As we have seen, it is impossible to return to the values sustained by the
Hippocratic tradition. Therefore, it is necessary to rethink medical profes-
sionalism within our particular context which in turn requires recognizing
the profound transformation of the medical profession in the last few decades
while acknowledging that such reconsideration is an inherently conserva-
tive undertaking in that it is bound to the moral traditions of physicians

(Miles, 2002, p. 46). As many scholars point out, a reconsideration of medical professionalism does not necessarily imply a return to old under-standings of medical practice (paternalism, physician-patient relationship, etc.) since they do not correspond to the reality of contemporary medicine (Pellegrino, 1987, p. 47; Thomasma, 1997, p. 128).

David Thomasma suggests a call to move "beyond contemporary bioethics to a moral philosophy of medicine" (Thomasma, 1997, p. 128). This would require relocating the analysis of the moral questions raised by medicine within the context of a philosophy of medicine. Thomasma sees in the current field of bioethics a problematic lack of normative content, which is the result of the absence of a dominant body of principles and methods (Jonsen, 1998, p. 345).[20] While he recognized that a universal ethics and an absolute certainty about right and wrong is misplaced, he asserts that "a moral philosophy of medicine consists in the *search* … for the normative and moral basis of the profession" based on "a *critical* examination of the foundations of medical ethics in medicine, of the sources and justifications for moral principles, duties, actions, and virtues, that have characterized the profession of medicine and its medical ethics" (Thomasma, 1997, p. 128, italics mine).[21]

This distinction between bioethics and a (moral) philosophy of medicine is important because the fields are concerned with distinct types of questions. On the one hand, the role of bioethics is to analyze the ethical, socio-political and legal questions related to the practice of medicine. On the other hand, the philosophy of medicine is concerned with the examination of the methodology, theoretical framework and logic inherent to scientific endeavour (i.e., physical and biological sciences). A *moral* philosophy of medicine is the recognition that medicine relies methodologically on a scientific basis (i.e., scientifically validated facts) for its explanation of diseases, malfunction of the bodily organs, and treatments, but, likewise, on a set of values and assumptions. Medical knowledge is value laden and requires the physician to make value judgments about medical facts (disease, pain, suffering) when applying such knowledge.[22] Thus, the nature of medical decisions makes the relationship between the physician and the patient a moral enterprise in the sense that most decisions are the combination of

1. technical considerations (i.e., the potential harms and benefits of particular procedures);
2. moral components (i.e., the respect of the patient's autonomy vs. professional integrity); and
3. socio-economic factors (i.e., cost containment issues vs. the patient's welfare), all of them generating moral concerns.

It is the act of analyzing and judging these various aspects that presupposes the moral dimension of medicine. On the one hand, medicine is a

science that deals with empirical research and scientific facts aiming at the restoration of health and the well-being of the patient according to a set of norms that constitute a diagnosis. On the other hand, however, the practice of medicine demands "practical wisdom" because the analysis the medical data provides space for difference in opinions but at the same time recognizes the normative dimensions of the value-judgments presupposed by scientific facts (Fullford, 1994, p. 200).

Furthermore, to avoid a status quo in our reflection on medical professionalism, a (moral) philosophy of medicine is indispensable on a second level because, contrary to bioethics, it provides insight as to what medicine is and what its goals are (Caplan, 1992). As Arthur Caplan remarks without some presuppositions about the nature of medicine, bioethics could not answer to some of the difficult moral questions raised by medical practice. The philosophy of medicine, he concluded, is "an essential foundation for bioethics" (Caplan, 1992, p. 67). Thus, a moral philosophy of medicine avoids two extremes in our reflection concerning ethical issues in medicine.

On the one hand, some could argue that discursive reasoning and the abandonment of particular irreconcilable moral commitments for the sake of political consensus could constitute the basis for ethical principles and moral actions. John Rawls exemplified this political move. He argued that in a modern democracy the distinction between what he calls "a pluralism of comprehensive religious, philosophical, and moral doctrines" and "a pluralism of incompatible yet reasonable comprehensive doctrines" is necessary in order to insure a neutral framework in which political consensus can take place (Rawls, 1993, xviii). The doctrines of the former kind are the source of disagreement and cannot constitute a basis for social collaboration. The latter kind represents the necessary conditions for social consensus and consequently establishes, it is argued, a morality in itself in modern democracies (Rawls, 1993, 1997). On the other hand, one could confine moral reflection exclusively in relation to the teaching of a particular tradition and mores (intrinsic to a specific community) independently of what professional values and obligations require.

Thus, the content of moral discourse and moral actions is restrained by individuals' (i.e., physicians, nurses) socio-political or religious background belonging to that particular community. In other words, such an understanding of morality holds that the outcome of the decision making process within a professional setting is almost exclusively the result of the practitioner's own moral commitments, based on the moral tradition of his/her community independently of professional obligations and values.

These two positions need critical assessment because they are problematic. In the first approach, the quest for political consensus raises the issue of the danger of emptying morality of its content and also depriving it of rigorous moral analysis. This "political move" transforms morality into a set of procedures designed to provide a justification for what is socially suitable

and acceptable for the sake of a particular social order. More importantly, if we accept the second approach, it implies that one's understanding of medicine and certain ethical issues related to it are understood only within particular communities independently of what the practice of medicine requires for professionals. For instance, we could image a physician belonging to a community that encourages, on a moral ground, the killing of people considered as burdensome for society (people in a vegetative state, for instance). It does not follow, however, that that particular individual can justify the killing based on his personal convictions while acting as a professional in a clinical setting. As a doctor this individual is obliged to act according to some particular professional standards.

Of course, one might answer that a professional association may impose on a minority of physicians the professional obligations to practice what would be considered as morally wrong action (i.e., abortion) for them. However, a distinction here is necessary. It is important to distinguish between refraining from partaking in unethical actions (which has no consequences for one's moral integrity) and imposing on others, through specific actions, one's moral views (i.e., the moral obligation to kill people burdensome for society). In the latter case, moral wrong is acted upon the patient and the family (by imposition) while in the second case one is free to refrain from participating in a specific action, thus leaving the decision to others and creating a moral space in which one can act as a professional and as a moral agent. Furthermore, even if a professional association would impose particular obligations contrary to one's convictions, there is always the possibility to resign or simply not be a member of the association. In United States, for instance, there is not a obligation to be a member of the AMA to practice medicine.[23]

These are complex sets of issues that need further developments. But what is important to keep in mind for the sake of this article is that medicine is practiced by a variety of people of different socio-cultural backgrounds who are required to respect fundamental professional principles and a set of moral norms regulating their practice. Undoubtedly, our social context reveals various communities with different competing and sometimes incompatible moral understandings. Nevertheless, despite the differences, it does not follow that some overlap between communities and moral traditions cannot occur. As Kevin Wm. Wildes argues, health care is a collaborative enterprise that does not limit moral problems to particular communities (Wildes, 2000, p. 141). Moral discourse in bioethics and medicine (moral philosophy of medicine), from a collaborative perspective, can take the form of what he calls acquaintanceship. In this type of moral relationship people do not necessarily share moral views but rank values (i.e., freedom, justice, etc.) differently and understand the differences that separate them from others. The result is that a moral discourse can be established between acquaintances through a web of partial understandings of moral issues, in spite of moral disagreements.

IV. CONCLUDING REMARKS

An analysis of the Hippocratic Oath, tradition, and ethos shows both their complexity and the multiple ways in which they are invoked as a basis for medical professionalism. Stephen Miles' interesting study, by its emphasis on the danger of pharmaceutical companies to the neglect of the transformation of medicine by government regulation, government insurance, and private insurance, shows how engaging contemporary studies are prisoner to particular contemporary moral and political perspectives. He shows by indirection how accounts of medical professionalism are strongly structured by particular social perspectives framed within particular cultures. Here one might recall his recasting of the Greek and Hippocratic sense of *diké* (justice) in service of his particular views regarding health care reform. His study also shows by indirection the power and allure of the Hippocratic tradition, which entrances people with a purported moral tradition over time, without substantiating that such a tradition exists. Indeed, it is interesting that Miles does not successfully show how the ethical principles in the Oath (and here again one must note that the Oath's sense of ethical principles is surely not ours) and the symbolic force of the Oath can direct the contemporary project of reclaiming a sense of medical professionalism. What he does show is that there is much re-imaging of what the Hippocratic Oath, tradition, and ethos should mean, not what they actually meant.

These brief reflections on the Oath and Stephen Miles' study of that Oath disclose major challenges in recapturing a coherent sense of medical professional identity and medical professionalism. It would be well to recall that the Oath is in fact puzzling because of the numerous levels of concerns it compasses beyond the ethical. It directs itself to religious concerns, to an esoteric sense of esprit-de-corps, and to special obligations binding students to teachers (and by extension medical professionals to each other). It is much more than an ethical text. Here is where the core misunderstanding may lie. Medical professionalism may be grounded in much more than the supposed universal moral commitments that most contemporary scholars attempt to read back into the Oath. It indeed compasses moral claims that could be understood in universal terms, but it is inevitably a particularistic document that aims at creating a particular sense of identity for the Hippocratic practitioners. One must take much more seriously the complexity of the Oath and the complexity of medical professionalism.

All of this substantiates the crucial need to take the philosophy of medicine seriously. Such a philosophy of medicine should turn to developing a medical-moral philosophy that can place or locate bioethics. An effort to revisit the philosophy of medicine seems necessary in the light to the current condition of bioethical reflection (e.g., the politicization of bioethics). This undertaking is crucial on three levels. First, contemporary medicine must think through what is involved in professional commitments, what is

necessary for professional identity, and what internal values should be nurtured by the profession. Second this assessment may draw strength from a critical appreciation of the extent to which, if any, contemporary medical professionalism is rooted in a Hippocratic tradition and morality. Third, the political, economic, and social aspects associated with medicine should be considered in terms of a philosophically enriched understanding of the final analysis of bioethical issues.

NOTES

1. The major attributes of *Hippocratic morality* can be summarized as follows: the first characteristic is that Hippocratic medicine is *individualistic*, that is, the physician acts always in the best interest of the patient, which implies the moral obligation of *beneficent* and consequently *nonmaleficent*. The aim of any medical procedure is the good of the patient independently of other factors, such as the ability to pay or the background of the patient (i.e., criminal). Other characteristics include confidentiality (willingness to restrain from divulging information); prohibition to practice euthanasia and abortion; refraining from sexual relationships with patients. In a nutshell, *Hippocratic morality* describes the physician as a professional whose *etiquette* reflects the attributes of a gentleman in his relationship with the patients and his family and his colleagues (Nutton, 1997, p. 38; see also Pellegrino & Thomasma, 1993, p. 184).

2. Interestingly, Ludwig Edelstein remarked that the Hippocratic Oath did not reflect consensus in Greek society concerning medical practice but rather the values and ideology of a small portion of Greek physicians: "the document originated in a group representing a small segment of Greek opinion. That the Oath at first was not accepted by all ancient physicians is certain. Medical writings, from the time of Hippocrates down to that of Galen, give evidence of the violation of almost every one of its injunctions. This is true not only in regard to the general rules concerning helpfulness, continence and secrecy. Such deviations one would naturally expect. But for centuries ancient physicians, in opposition to the demands made in the Oath, put poison in the hands of those among their patients who intended to commit suicide; they administered abortive remedies, they practiced surgery" (Edelstein, 1967, p. 62).

3. Pellegrino strongly stresses the universal validity of the oath: "It was in the early Middle Ages that the ethics of the Hippocratic oath were first universalized. The concept of the physician as a religious man—Christian, Moslem, or Jew–required him to serve the sick as brothers under the fatherhood of God. The oath was cleansed of its pagan references and found its sources refurbished by the humanism of the great religions. This is the wellspring for much of medical ethics in nineteenth-century America " (Pellegrino & Thomasma, 1981, p. 195). On the other hand, however, Pellegrino recognizes that the Hippocratic norms cannot be absolutes: "The Hippocratic norms can no longer be regarded as unchanging absolutes but as partial statements of ideals in need of constant reevaluation, amplification, and evolutions" (Pellegrino, 1987, p. 47).

4. Hippocratic medicine became widespread throughout the Judeo-Christian world as a Christianized version of the Oath was created. See Jones (1924) for the text of the Christianized version. In the context of the Christianity of the first centuries, Hippocratic medicine and its ethical teachings was not dismissed simply on the ground that it was "worldly" wisdom. According to Owsei Temkin, "the Hippocratic oath in its pagan form was certainly a major document of medical ethics until at least about the end of the fourth century" (Temkin, 1991, p. 182; see also pp. 126–145). Likewise, Loren C. MacKenney pointed out that in the Middle Ages, Hippocratic ideas concerning the conduct of physicians persisted "borrowing [much more] from Hippocrates than from Biblical and clerical authorities … From the non-medical viewpoint of lay historians who are interested in pre-Renaissance classicism, the evidence presented is noteworthy. It corroborates the thesis of the persistence of Hippocratic ideas in an unbroken line through the early, as well as late, Middle Ages, and in non-Salernitan centers" (MacKenney, 1952, pp. 2–3). However, some scholars have pointed out that the Oath's historical value is rather problematic. As Nutton remarks, "the evidence for the last two centuries is, to put it mildly, equivocal, and the further back in time one goes, the harder the task becomes. Pious hopes from Scribonius Largus, a sentence in Gregory of Nazianzus, Arabic reconstructions of Classical Antiquity, and the Constitutions of Melfi do not inspire great faith in the universality of the Oath, when contrasted with the numerous occasions when

one can state that the Oath was *not* sworn" (Nutton, 1997, p. 47). Finally, Miles also stresses the fact that the "Oath was rarely mentioned during the first 1,500 years of the Christian era and was peripheral to the ethics of medicine of the millennium of Christianity, which based its ethic on love, charity, and compassionate empathy" (Miles, 2004, p. 28). Vivian Nutton likewise remarks that the Oath was rarely mentioned in Antiquity as a core reference in medical ethics and that "it may not have generally sworn until the sixteenth century at the earliest" (Nutton, 1995, p. 29).

5. I purposely omit discussion of the author of the Oath. Due to the problems surrounding the authorship of the document, it would go beyond the scope of our analysis. In brief, however, two main theories have been advanced concerning the source of the Oath. On the one hand, classicist Ludwig Edelstein argues that a Pythagorean school wrote the Oath. On the other hand, however, people such as Savas Nittis who claims that Hippocrates wrote the Oath himself, contest this view. For further readings on both positions see Edelstein (1943); Carrick (1985, 71–72); Nittis (1940); and Nutton (1993, 10–37).

6. Although the Hippocratic Oath has been accepted as one of the major sources for medical ethics and was considered as a "taken-for-granted ethical system," it started to be challenged in the mid-1960s in the United States. Hippocratic ethics came under criticism as the result of a series of changes in society. As Pellegrino and Thomasma remark, "better education of the public, spread of participatory democracy through civil rights, feminist, and consumer movements, decline in the sense of communally shared values; heightened senses of ethnicity; and a distrust of authority and institutions of all kinds. These forces were accentuated in medicine by the specialization, fragmentation, institutionalization, and depersonalization of health care that occurred simultaneously with an expansion in the number and complexity of medical ethical issues" (Pellegrino & Thomasma, 1993, p. 185).

7. Statistics (USA and Canada) over the last 70 years show that by 1928 only 20 medical schools administered the Oath or a version of it—interestingly none in Canada. In 1965, out of 97 medical schools 68 referred to a medical oath whereas 12 years later, in 1977, 108 out of 128 medical schools used a medical oath, and by 1989, 119 of them (Nutton, 1997, p. 35).

8. Miles notes that the maxim "*Primum non nocere*" is not found in the Oath itself but mentioned in another work of the Hippocratic Corpus, more precisely in *Epidemics I*. Albert R. Jonsen examines the maxim "primum non nocere" and identifies four usages: 1) medicine as moral enterprise, 2) due care, 3) risk-benefit ratio, and 4) benefit-detriment equation. Each presupposes "different forms of ethical argument" which reflect various purposes. For a detailed analysis see Jonsen (1977).

9. Nutton argues that during the period when the Hippocratic Oath was written medicine was still consider as something "holy" but did not exclude economic concerns: "Medicine is still seen as something holy, to be revealed only to the holy, to the initiate, and its secrets are to be kept within the small group … One of the few facts known for certain about the great Hippocrates was that he was prepared to teach medicine for a fee to anyone who could afford it … In all the later documents referring to the appointment and activities of such practioners [civic physicians], there is never any formal injunction on a doctor to treat the poor free of charge, although, of course, social pressures and individual inclination might well lead to such generosity" (Nutton, 1992, pp. 19–20).

10. This translation is as given by Edelstein (1967, p. 3).

11. Miles founds his explanation on how oaths were used in Ancient Greeks in Thucydides' account of the Poloponnesian War (Miles, 2004, p. 168 footnote 2).

12. According to R. M. Veatch and F.G. Miller (2001, p. 555) the notion of an internal morality for medicine was derived from the concept of a *practice*, defined by Alasdair MacIntyre as "any coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realized in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity, with the result that human powers to achieve excellence, and human conceptions of the ends and goods involved, are systematically extended (MacIntyre, 1984, p. 187). It was then incorporated in the works of, among others, Edmund Pellegrino, Franklin Miller, and Howard Brody, each scholar with his own particular understanding of the concept. For an overview of the debate between those who defend and those who object to the concept of an internal morality of medicine see the special issues of *The Journal of Medicine and Philosophy* co-edited by R. M. Veatch and F. G. Miller (2001, 26:6).

13. Whether oaths do not compel ethical behavior or are simply human instruments is debatable. As far as Ancient Greece, there is evidence that Greeks physicians acknowledged the gods and goddesses in their practice. The relationship between religion and medicine has always been present in traditional cultures (e.g., Egypt, Babylon). From the beginnings of medical practice, religious aspects such as causation theories of illness have been incorporated into the understanding of disease. The sixth

century B.C., however, marks a turning point in the history of Western thought and medicine (Sigerist, 1943, p. 133). The Greeks transformed medicine into a rational system of analyzing diseases and removed, to some extent, the mythological and transcendental aspects. They organized medical practice through the Hippocratic Corpus that includes the Hippocratic Oath. Greek Hippocratic physicians, however, did not limit their practice exclusively to physiological phenomena. In their attempt to understand disease they retained a transcendental element in their practice. In fact, a theistic approach was part of their medical philosophy. In *Decorum*, the author associates the practice of medicine with the acknowledgment of the gods: "now with medicine a kind of wisdom is an associate, seeing that the physician has both these things and indeed most things. In fact it is especially knowledge of the gods that by medicine is woven into the stuff of the mind" (*Decorum*, V and VI). In *Prognostic*, the writer encourages physicians to determine the nature of disease and also to discern whether "there is anything divine" in it (*Prognostic*, I, n.1).

14. Julia E. Connelly regards American culture as "a huge obstacle" for medical professionalism in this country. She identifies six issues that are potential struggles for those who whish to enter the medical profession:

1. Professionalism requires that physicians put patients' interests first. However, this concept is difficult to articulate in definitive terms.
2. The denial of personal and professional limitations continues to be modeled throughout medicine.
3. Ongoing acceptance in medicine that emotional distance between patient and physician is paramount. Minimization of the importance of personal emotions.
4. Professionalism is too often defined in terms of technical expertise in medicine, occulting the central feature of the patient-physician relationship.
5. Lack of altruism and social concerns in the medical professional.
6. Confusion concerning the role of self-interest versus the public interest. This erodes public and professional trust (2003, pp. 181–182).

15. See Light (1993) for an account of the transformation of health care delivery in United States.

16. For an analysis of the social transformation of American medicine see Starr (1982).

17. The frustration is not only expressed by the medical profession. According to Sylvia R. Cruess and Richard L. Cruess there is increasing public discussion "for a return of medical professionalism, with its core values of scientific expertise and altruism" (2000, p. 668).

18. For an analysis to the rise in power of bioethics see Engelhardt (2002b). For a broader perspective see Jonsen (1998).

19 For a full analysis on the concept of a profession see Freidson (1970), Hafferty & McKinlay (1993).

20. As Jonsen points out "bioethics has no dominant methodology, no master theory. It has borrowed pieces from philosophy and theology…In addition to these philosophical and theological pieces, fragments of law and the social sciences have been clumsily built onto the bioethical edifice" (Jonsen, 1998, p. 345).

21. Caplan makes such distinction and points out that the philosophy of medicine is "the study of the epistemological, metaphysical and methodological dimensions of medicine" whereas bioethics aims at reflecting on how such knowledge raises moral questions. (Caplan, 1992, pp. 69, 71).

22. See, for instance, Engelhardt: "To find that value judgments are core to our language of health and disease is not to deny that there are real causes of disease or real empirical factors important in maintaining health or causing disease. It is, rather, to recognize the obvious – that to speak of being ill or being well turns on our value judgments about the world. To talk about health and disease (i.e., explanations of our states of being ill or well), presupposes evaluations of ourselves and our ambience" (Engelhardt, 1976, p. 260).

23. Interestingly not all physicians in the United States are members of the American Medical Association. Statistics show that membership rose from 51% in 1912 to 73% in 1963. In 1990, membership was less than 50% (Krause, 1996, p. 45).

REFERENCES

Ackerknecht, Erwin H. (1982). *A short history of medicine,* rev. ed. Baltimore: The Johns Hopkins University Press.

Caplan, A.L. (1992). Does the philosophy of medicine exist? *Theoretical Medicine,* 13, 67–77.

Carrick, Paul. (1985). *Medical ethics in Antiquity.* Dordrecht: D. Reidel Publishing Company.

Connelly, J.E. (2003). The other side of professionalism: Doctor-to-doctor. *Cambridge Quarterly of Healthcare Ethics,* 12, 178–183.

Cruess, S.R., & Cruess, R.L. (2000). Professionalism: A contract between medicine and society. *JAMC,* 162(5), 668–669.

Edelstein, L. (1943). *The Hippocratic Oath: Text, translation and interpretation.* Baltimore: The Johns Hopkins University Press.

Edelstein, L. (1967). O. Temkin & C.L. Temkin (Eds.), In: *Ancient medicine.* Baltimore: The Johns Hopkins University Press.

Engelhardt, Jr., H.T. (1976). Ideology and etiology. *The Journal of Medicine and Philosophy,* 1, 256–268.

Engelhardt, Jr., H.T. (1986). The foundation of bioethics. Oxford: Oxford University Press.

Engelhardt, Jr., H.T. (2002a). Managed care and the deprofessionalization of medicine. In: William B. Bondeson & James W. Jones (Eds.), *The ethics of managed care: Professional integrity and patient rights* (pp. 93–107). Dordrecht: Kluwer Academic Publishers.

Engelhardt, Jr., H.T. (2002b). The ordination of bioethicists as secular moral experts. *Social Philosophy & Policy,* 19, 59–82.

Freidson, E. (1970). *Profession of medicine.* Chicago: The University of Chicago Press.

Fulford, K.W.M. (1994). Not more medical ethics. In: K.W.M. Fulford, G.Gillett, and J.M. Soskice (Eds.), *Medicine and moral reasoning* (pp. 193–205). Cambridge: Cambridge University Press.

Hafferty, F.W., & McKinlay, J.B. (1993). *The changing medical profession. An international perspective.* Oxford: Oxford University Press.

Hanson, M.J., & Callahan D. (Eds.) (1999). *The goals of medicine.* Washington, D.C.: Georgetown University Press.

Hippocrates. (1923a). *Decorum.* Trans. W.H.S. Jones. Cambridge: Harvard University Press.

Hippocrates. (1923b). *Prognostic.* Trans. W.H.S. Jones. Cambridge: Harvard University Press.

Hippocrates. (1923c). *Arts.* Trans. W.H.S. Jones. Cambridge: Harvard University Press.

Johansen, J. (2002). *The charter on medical professionalism: The new Hippocratic Oath?* [On-line]. Available: http://www.pregnantpause.org/ethics/medprof.htm

Jones, W.H.S. (1923). *Hippocrates,* vol. 1, trans. W.H.S. Jones. Cambridge: Harvard University Press.

Jones, W.H.S. (1924). *The doctor's Oath: An essay in the history of medicine.* New York: Cambridge University Press.

Jonsen, A.R. (1977). Do no harm: Axiom of medical ethics. In: S.F. Spicker & H.T. Engelhardt (Eds), *Philosophical medical ethics: Its nature and significance.* Dordrecht: D. Reidel Publishing Company.

Jonsen, A.R. (1998). *The birth of bioethics.* Oxford: Oxford University Press.

Krause, E.A. (1996). *Death of the guilds.* New Haven: Yale University Press.

Light, D.W. (1993). Countervailing power: The changing character of the medical profession in the United States (pp. 69–79). In: F.W. Hafferty & J.B. McKinlay, *The changing medical profession. An international perspective.* Oxford: Oxford University Press.

MacIntyre, A. (1984). *After virtue* (2nd edition). Notre Dame: University of Notre Dame Press.

MacKenney, L.C. (1952). Medical ethics and etiquette in the early Middle Ages: The persistence of Hippocratic ideals. *Bulletin of the History of Medicine, 26,* 1–31.

Miles, S.H. (2002). On a new charter to defend medical professionalism: Whose profession is it anyway? *Hastings Center Report, 32,* 46–48.

Miles, S.H. (2004). *The Hippocratic Oath and the ethics of medicine.* Oxford: Oxford University Press.

Nittis, S. (1940). The authorship and probable date of the Hippocratic Oath. *Bulletin of the History of Medicine, 8,* 1012–1021.

Nutton, V. (1992). Healers in the medical market place: Towards a social history of Graeco-Roman medicine (pp. 15–58). In: A. Wear (Ed.), *Medicine in society.* Cambridge: Cambridge University Press.

Nutton, V. (1993). Beyond the Hippocratic Oath. In: A. Wear, J. Geyer-Kordesch, & R. French (Eds.), *Doctors and ethics: The earlier historical setting of professional ethics* (pp. 10–37). Amsterdam: Rodopi.

Nutton, V. (1995). Medicine in the Greek world, 800–50 BC. In: L. I. Conrad, M. Neve, V. Nutton, R. Porter, & A. Wear (Eds.), *The western medical tradition. 800 BC to AD 1800* (pp. 11–39). Cambridge: Cambridge University Press.

Nutton, V. (1997). Hippocratic morality and modern medicine. In: H. Flashar et al. (Eds.), *Médecine et morale dans l'Antiquité* (pp. 30–63). Geneva: Fondation Hardt.

Pellegrino, E.D., & Thomasma, D.C. (1981). *A philosophical basis of medical practice.* New York: Oxford University Press.

Pellegrino, E.D. (1987). Toward an expanded medical ethics: The Hippocratic ethic revisited. In: R.J. Bulger (Ed.), *Search of the modern Hippocrates* (pp. 45–64). Iowa City: University of Iowa Press.

Pellegrino, E.D., & Thomasma, D.C. (1993). *The virtues in medical practice.* New York: Oxford University Press.

Pellegrino, E.D. (1999). The goals and ends of medicine: How are they to be defined? In: M.J. Hanson & D. Callahan (Eds.), *The goals of medicine* (pp. 55–68). Washington, D.C.: Georgetown University Press.

Rawls, J. (1993). *Political liberalism.* New York: Columbia University Press.

Rawls, J. (1997). The idea of public reason revisited. *The University of Chicago Law Review, 64,* 765–807.

Rich, Ben A. (1993). Postmodern medicine: Deconstructing the Hippocratic Oath. *University of Colorado Law Review, 65,* 77–136.

Sigerist, H. E. (1943). *Civilization and disease.* Chicago: The University of Chicago Press.

Starr, P. (1982). *The social transformation of American medicine.* New York: Basic Books.

Temkin, O. (1991). *Hippocrates in a world of pagans and Christians.* Baltimore: The Johns Hopkins University Press.

Thomasma, D.C. (1997). Antifoundationalism and the possibility of a moral philoso-
     phy of medicine. In: D.C. Thomasma (Ed.), *The influence of Edmund
     D. Pellegrino's philosophy of medicine.* Dordrecht: Kluwer.
Veatch, R.M. (1988). The Hippocratic ethic is dead. *The New Physician,* 48, 41–42.
Veatch, R.M., & Miller, F.G. (2001). The internal morality of medicine. *The Journal
     of Medicine and Philosophy,* 26(1).
Wildes, S.J., K.Wm. (2000). *Moral acquaintances.* Notre Dame: University of Notre
     Dame Press.