

# Medical Ethics: Entering The Post-Hippocratic Era

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The pace and depth of the transformations now occurring in the ages-old structure of medical ethics are truly unprecedented. More change has taken place in the last 15 years than in the entire previous history of medicine and the health professions. The ancient edifice of Hippocratic ethics has been disassembled, and we are entering what can without exaggeration be called the "post-Hippocratic" era.

What do these changes portend for the future of medical ethics? What are their origins? What will medical ethics look like in the twenty-first century? What can be salvaged from the past? What must be discarded? Should the ancient edifice be restored? Will physicians ever again agree on the set of obligations, duties, or virtues that ought to define the ethical physician?<sup>1</sup>

Answers to these questions constitute the most important agenda for medical ethics in the years ahead. How we answer them will define what it is to be a physician, and that answer will have an enormous influence on what physicians do and what patients can expect when they seek help from our profession.

It would be foolhardy to suggest that this brief essay will answer questions of such moment. However, I believe there is value in examining the nature of the changes and challenges confronting the Hippocratic tradition and to suggest what elements seem likely to be retained, what ones are likely to be abandoned, and what the tentative shape of medical ethics will be as we enter this new era.

## Sources of the Metamorphosis of Medical Ethics

The metamorphosis in medical ethics today has two sources: the first is the extraordinary expan-

sion of capabilities that scientific advance has conferred on medicine; the second is the convergence of powerful socioeconomic and political forces peculiar to our times. The first has given rise to biomedical ethics. The second gives rise to medical ethics proper—the obligation of physicians to sick people, that is to say, the ethics of the physician as physician.

The ethical challenges arising out of medical progress are now widely discussed and debated among physicians, ethicists, lawyers, and the general public. The quandaries of *in vitro* fertilization, surrogate parenting, gene mapping, behavior modification, withdrawal of life-sustaining treatment, organ transplantation, artificial hearts, etc., are the subject of a vast and growing literature. These will not detain us here—not because they are not of crucial importance, but because the changes taking place in the structure of the profession itself are even more important. This is the realm of medical ethics proper, the range of obligations, duties, principles, and guidelines that defines ethical conduct in the relations between physician and patient and physician and society. It is this segment of our post-Hippocratic journey on which I wish to concentrate.

The changes being effected in medical, as distinguished from biomedical, ethics are less the result of scientific advance than of sociopolitical and economic forces that have altered the societal fabric within which medicine exists. Only some of the more powerful forces need to be mentioned: the rise of participatory democracy in every walk of life; the civil rights, women's, and consumer rights movements; the growing distrust of institutions, authority, and elitism; the entry of legal and economic considerations into medical decisions; and, perhaps most powerful of all, the moral heterogeneity of American society.

These forces that have stirred up controversy and change in American life—and in other countries as well—are reshaping society's and the medical profession's notion of what a physician should be, what is expected of him or her, and

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whether there is anything ethically unique about the medical profession.

These questions would have amazed our medical forebears perhaps as much as, or more than, the phenomenal progress of medical science. For them, professional ethics seemed to have been settled for all time by the immutable axioms of the Hippocratic *Oath* and the deontological treatises of the Hippocratic corpus. Our forebears could not have foreseen the ubiquity and power of the sociopolitical forces reshaping our society and their impact on the most sensitive phenomenon of medicine—the physician-patient relationship. This is the moral nucleus of medical ethics, the part most of us, until recently, felt was secured for all time by the Hippocratic ethos. Although we know that not every one of the Hippocratic precepts was respected by every physician in every era, the fundamental probity of the Hippocratic ethic was accepted as the standard of medical conduct for more than two millennia. Those who violated it were moral and professional pariahs. In spirit and often in specific content, the same standards of conduct were expected of the Indian and Chinese physician as well.<sup>2,3</sup>

In the last two decades, every one of the Hippocratic precepts has been challenged. Some have already been dropped, some changed, some reinterpreted, and some retained. The task of professional ethics today is the reconstruction of medical ethics from the ground up. A simple restoration of the ancient edifice, for which many physicians hope, will not be possible. Too much was not foreseen in the ancient code, too much that is pertinent today was left out, and too much lacked philosophical justification. Our challenge is to discern what of the old ethic should be retained, what should be modified, and what added without losing the morally viable elements of an ethos that has been among the most noble commitments that any group of humans has made to the welfare of others.

## The Deconstruction of the Hippocratic Precepts

Let me begin by examining some of the drastic changes being effected in the ethical substance of the Hippocratic ethic. A few instances will suffice to illustrate the kind and extent of metamorphosis now taking place. I will concentrate on the *Oath*, its preamble, and eight ethical precepts, with only

passing reference to the other deontologic treatises of the Hippocratic corpus.<sup>4,5</sup>

### The Oath

The preamble of the *Oath* exhorts the student to treat his teacher as a parent, to share his substance with him, relieve his necessities, teach his sons the art, and to keep the secrets of that art within the brotherhood. These precepts are long out of use and properly so. This concept of medicine as a “brotherhood,” has come under serious criticism as sexist, elitist, monopolistic, and wholly inappropriate in democratic societies. Medical knowledge is not the property of a fraternity. It belongs to the community for the service of the sick. The profession holds medical knowledge in trust. To isolate it from those for whom it is intended to benefit is to violate that trust. Medical ethics is a concern of the public as well as the profession. Whatever advantages the idea of a brotherhood might have had, it is outweighed by medicine’s social orientation.

### Precept 1

The most serious and most problematic challenge to the Hippocratic ethic has been directed at the first of the truly ethical precepts of the *Oath*: “I will use treatment to help the sick, according to my ability and judgement but never with a view to injury or wrong-doing.”<sup>6</sup> This pledge points to what are identified today as the principles of beneficence and nonmaleficence.

No one disagrees with the latter part of this statement, which commits the physician to nonmaleficence. Indeed, many would reduce the whole of professional ethics to nonmaleficence as stated here and in the *Epidemics*.<sup>7</sup> It is the first part of this precept, the invocation of beneficence, according to the physician’s judgment, that is the center of controversy. Most observers see in this precept the origins of the “paternalist” conception of the physician-patient relationship, which many physicians interpret as justification for a benign authoritarianism. Today, the paternalism model is being supplanted by an autonomy model in which the locus of decision making is shifted from the physician to the patient. On the autonomy model, respect for persons dictates that the physician follow the patient’s values and wishes or those of a valid surrogate (for incompetent patients) in clinical decisions. The opposition of

these two models points to an important distinction. Namely, the medical view of the patient's good is not necessarily synonymous with the patient's own view of his or her best interests.

Recently, David C. Thomasma and I have explored the concept of the patient's good in some detail.<sup>8</sup> The patient's good is a complex notion. It consists not only in the good that medicine can achieve, but also in the way a medical intervention fits the patient's notion of what is considered a good life—one consistent with the patient's values, both material and spiritual.

In our view, autonomy and beneficence need not be in conflict. Indeed, it is difficult to conceive of beneficence that violates the autonomy and respect for persons, which is so integrally tied to the very humanity of the patient. Thus, we speak of "beneficence-in-trust."

Paternalism, therefore, is not the equivalent of beneficence, because paternalism may violate the respect we must have for other persons as persons. Our patients have a moral claim on us to respect their freedom to live their lives as they see fit. That freedom should be limited only if it results in harm to third parties or involves violating some deeply held moral principle to which the physician is committed. The physician can justifiably withdraw from the care of the patient who asks him to violate his own conscience.

The opposition of the autonomy and the paternalism models has created a whole new domain of moral conflict. Although many physicians still feel that they know best, that patients cannot really comprehend the nature of a clinical decision, that illness impairs the patient's autonomy, and that, as a result, informed consent is an illusory concept, the weight of social and legal opinion is swinging increasingly in the direction of patient self-determination. So much is this the case that autonomy threatens to become an absolute principle. Its limits must be carefully delineated, while retaining the concept of respect for persons.

### **Precept 2**

The second Hippocratic precept is the admonition against giving any deadly medicine: "Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course."<sup>9</sup> Many commentators take this to be a sanction against euthanasia. While the proscription against euthanasia is still generally respected, it has been abro-

gated in private and also publicly in some countries.<sup>10,11</sup> In the United States, one recent court decision carried the implication that physicians ought to assist competent patients who decide to end their lives.<sup>12</sup> There is a real likelihood that direct voluntary euthanasia will be legal in some states very soon. In California, a referendum that might make this possible missed being placed on the ballot this year (1988).<sup>13</sup>

### **Precept 3**

The third Hippocratic precept is the admonition against abortion: "I will not give a woman a pessary to cause abortion." As is well known, this proscription has been widely abrogated by law in the United States and in many other countries. I will refer to this precept again below.

### **Precept 4**

The fourth precept asks that the physician pursue his life and art with "purity and holiness." This precept reflects the ascetic elements of the Pythagorean philosophy, which inspired the author(s) of the *Oath*. It is doubtful if it was ever seriously honored by the majority of physicians. Today, we tend increasingly to separate personal morals from professional behavior, sometimes to an unfortunate degree. Yet, realistically, were we to apply such a precept, we would face the impracticality of regulating private morals—a dubious and impossible undertaking in a morally pluralistic society.

### **Precept 5**

The fifth precept: "I will not use the knife, not even verily, on sufferers from stone," is usually interpreted as a warning against surgery or "cutting" for the stone, leaving it to ". . . practitioners of this sort of work." This precept is still well respected today, if we interpret it as a call for competence and specialization.<sup>14,15</sup> This is one part of the ancient tradition that is unaffected by the forces effecting changes in other parts of the Hippocratic ethic.

### **Precept 6**

The sixth precept urges the physician to enter the patient's home for the benefit of the sick and to

refrain from mischief and corruption. This is really a paraphrase of the first precept. Like it, the principles of both beneficence and nonmaleficence are enunciated together.

#### **Precept 7**

The seventh precept forbids seduction of the members of the household of the sick person. It is difficult to know the extent to which this admonition was, or is, honored; however, recently, a small number of psychiatrists have suggested that having sexual relations with their patients is morally permissible or even therapeutic.<sup>16,17</sup>

#### **Precept 8**

The eighth precept enjoins confidentiality with respect to ". . . whatsoever I shall see and hear in the course of my profession, as well as outside my profession . . ." <sup>18</sup> Important as it is to physician-patient relations, there are good reasons why confidentiality has become less and less of an absolute. In an interdependent society, individual decisions may have injurious effects on others. In the interests of justice, a physician might be compelled to violate the confidentiality of a patient; for example, a commercial airline pilot or railroad engineer who uses drugs on the job; a husband seropositive for HIV infection who refuses to tell his pregnant wife; or a homicidal psychotic who threatens the life of another.

This cursory review is not intended to show that some physicians violate the Hippocratic precepts. That has always been true. Rather, what is significant is that the moral validity of most of the precepts themselves are questioned or judged to be ethically unsound by many ethicists and physicians. With the exception of the precepts of non-maleficence and competence, little is left of the Hippocratic *Oath* that is held in common by all physicians today.

These transformations most clearly reveal the growing divergencies in fundamental philosophical and religious beliefs about political philosophies (e.g., autonomy, the elitist conception of Hippocratic ethics), sexual mores (e.g., sexual relations with patients), private morality (e.g., definition of a pure life), and about the meaning and purposes of human life (e.g., the precepts on abortion and euthanasia).

Similar difficulties can be pointed out in the ethical assertions in other works of the Hippo-

cratic corpus—e.g., the *Physician, Law, Decorum, On the Art, and Ancient Medicine*.

For example, *Decorum* includes altruism or "disinterestedness"<sup>19</sup> as an essential virtue of the physician. Yet, today, there are not only surgeons who refuse to treat patients with HIV infection for fear of contagion,<sup>20</sup> but also obstetricians and orthopedists who withhold their services for fear of malpractice suits.<sup>21,22</sup> There are also many physicians who will not treat the poor.<sup>23,24</sup> Indeed, the current legitimization of physician self-interest may be the greatest challenge to professional ethics in our time.<sup>25</sup>

Elsewhere, other conflicts can be noted between the Hippocratic ethic and current ethical beliefs. In two places, for example, the physician is expressly advised not to tell the patient or his family about the severity of the illness and to act towards the patient as one who commands to one who obeys.<sup>26,27</sup> Both of these precepts are directly contrary to the emergent principle of autonomy.

### **Some Omissions in the Hippocratic Ethic**

In addition to these examples of conflict between the ancient precepts and contemporary ethical thinking, there are some serious omissions in areas of great concern in contemporary society. Again, only some examples can be given.

One omission is the failure to mention questions of social ethics such as the possibility of a physician's competing obligations to society and to the individual patient. This problem is evident today in questions involving the physician's role in the rationing and allocation of health care resources.<sup>28</sup> In our time, the roles of bureaucrat, entrepreneur, proletarian, or scientist are being thrust upon physicians by necessity and by societal pressures. The ancient canons provide no guidelines on how to resolve some of the more acute conflicts that occur when these roles overlap with that of healer.

Another omission is in the realm of medical economics, which looms so large for physicians in capitalist as well as in collectivist countries. References in the Hippocratic works to care of the indigent are ambivalent and vary from book to book.<sup>29,30</sup> The problems of medical entrepreneurship, for-profit medicine, and investment in, and ownership of, medical facilities are peculiarly modern. Although Plato, in the *Republic*,<sup>31</sup> did make a distinction between the art of medicine

and the art of making money, specific reference to the conflict between altruism and financial self-interest is missing in classical texts.

The Hippocratic corpus is also silent on the subject of the "health care team." The Hippocratic physician was assisted in the care of patients by a student or the patient's family. Because the professional nurse, dentist, and the many technicians necessary in modern medical care simply did not exist in ancient times, the ethics of team obligations, conflicts, and cooperation were not matters of ethical moment.

Finally, the Hippocratic ethic does not deal with the ways in which law and medical ethics may come into conflict. The extreme examples in our day are the Nazi physicians who actively participated in genocide or illicit human experiments,<sup>32</sup> the enlistment of psychiatrists in the removal of political enemies to asylums on the pretext of insanity,<sup>33,34</sup> or the participation of physicians in torture or executions.<sup>35,36</sup> Even more subtle instances of potential conflict between legal and moral justification are beginning to appear where abortion, surrogate motherhood, embryo freezing or "preembryo" experimentation, and the sale of organs and tissues are sanctioned by law. In these instances, the personal or professional ethics of the physician may be subject to overt or subtle pressures unimaginable to the Hippocratic physician. The modern physician must be constantly reminded that the law and ethics are two separate domains and that moral accountability at times transcends law and social custom.

There are serious problems in reliance on a set of texts that is 2500 years old. First is the problem of language. The discrepancies in ancient and modern meaning and usage are notorious. Second is the difference between the textual meaning as a whole as it was taken up in ancient times and as it is perceived today. Finally, there is the overlay of commentaries and interpretations that may obfuscate rather than illuminate the ancient tradition. These textual difficulties constitute another good reason for rethinking the ancient codal foundations of professional ethics.

I list these omissions in the Hippocratic ethic not to deprecate that noble edifice. It has served humankind long and well. Indeed, the ethics of medicine, when it is faithfully observed, is one of the higher achievements of humanity. We in medicine should be proud that medicine was the first profession to build its art on a truly ethical framework.

The question we are faced with today is how to reconstruct the moral foundations of a professional ethic that will more explicitly take into account the metamorphoses and omissions I have just outlined. If, as I have suggested, we are now already in the post-Hippocratic era, how do we find our way into the future? Is it still possible in a morally heterogeneous society to find some set of common moral norms that will bind all physicians? Or is the whole project of professional ethics effectively at an end?

I would like to suggest some steps on the way to a restructured medical ethics equal to the challenges of the twenty-first century. I shall touch only on professional ethics—not on the vast array of bioethical quandaries generated by medical progress.

### **Restructuring the Moral Foundations of Medicine**

The steps toward a reconstruction of professional ethics are three: (1) establishing a moral philosophy of medicine, (2) salvaging what is still viable from the Hippocratic ethic, and (3) adding certain missing elements.

#### *The Need for a Moral Philosophy of Medicine*

Given the moral heterogeneity of modern societies and the cosmopolitan character of scientific medicine, any sound moral philosophy of medicine will need to be "internal" to medicine itself. It cannot be derived solely from any external philosophical system as in the past. Such a moral philosophy would be based in four things: the phenomena of human illness, the special nature of medical knowledge, the moral nature of clinical decisions, and the claim of medicine to be a profession. Until recently, professional ethics consisted largely of moral assertions and statements defining the moral behavior physicians should exhibit. These assertions have been made, however, without explicit or formal moral argumentation. This is the genre to which the Hippocratic ethic belongs, as do most subsequent treatises and codifications of medical ethics up to our day. In most cases, the philosophical presuppositions inherent in these moral pronouncements were derived from philosophical systems external to medicine itself.

Medical ethics as a formal discipline began seriously only two decades ago when the moral asser-

tions that had sufficed for so many centuries became problematic. For the first time, these assertions were subjected to formal analysis and treated as a special case of general ethics. Professional philosophers who ignored medical ethics for most of medicine's history sought clarification of its content in terms of prima facie principles of beneficence, autonomy, and nonmaleficence from which they derived the secondary principles of confidentiality, truth-telling, and fidelity to promises. This is the analytical approach of Anglo-American ethics based largely in the philosophies of Hume, Kant, and J.S. Mill.

Salubrious as it has been, the current approach to professional ethics has certain deficiencies. It leaves an inferential gap between principles and their application in concrete clinical cases. It is not convincing to physicians, because it is derived from philosophies external to medicine. Moreover, as it functions today, principle-based ethics does not deal directly with the role-specific obligations of physicians, nurses, hospital administrators, etc. Finally, Anglo-American ethics pays little attention to the ethics of virtue.

All of this points to the need for a moral philosophy specific to medicine. Such a philosophy would be prior to medical ethics. It should provide philosophical foundations for defining what constitutes good medicine, the good physician, and the moral obligations that derive from these definitions. A moral philosophy of medicine would itself be grounded in a philosophy of the nature of health, illness, suffering, and healing; the logic and epistemology of medical knowledge; and, especially, in the nature of the physician-patient relationship. The dominant mode of medical ethics today does well at clarifying some of the questions, but to answer them adequately requires a fully developed theory of medicine and medical morality.

Such a theory of medicine and medical morals exists only in fragmentary and suggestive forms in the history of medicine. In the past, the philosophical foundations of medicine were drawn from the dominant philosophical schools of the times. Hellenic and Roman medicine relied on remnants of all the major schools of Greek philosophy. Medieval medicine was shaped by the Christian, Jewish, and Moslem religions. Since the eighteenth century, Anglo-American medical ethics has been based in the philosophies of Locke, Bentham, Hume, and J.S. Mill. Remarkably, even the physicians who were philosophers, such as Locke,

Jaspers, or William James, did not develop moral philosophies of medicine.

The first genuine suggestion of a moral philosophy specific to medicine is found in the first century A.D. in the work of the physician/pharmacist Scribonius Largus. Here, for the first time, we encounter the words "humanity," "compassion," and "profession."<sup>37</sup> Scribonius insists that these qualities are intrinsic to being a physician. Without them, the physician ceases to be a physician. Scribonius' conception was itself derived from Panaetius' Stoic teachings on role-specific duties as transmitted to the Roman world in Cicero's *De Officiis*.<sup>38</sup> On this view, each role in life comes with certain specific duties. It is the derivation of these duties that constitutes the "internal" morality of medicine—a set of obligations drawn from the nature of clinical medicine as a special kind of human activity.

#### *What Is Still Viable in the Hippocratic Ethic?*

Even though we lack the first essential step of a moral philosophy, we can take the next step in the reconstruction of professional ethics by salvaging the still-viable elements of the old edifice. Here are some examples of what I mean:

As we saw above, the most important principles of the *Oath* are contained in its first genuinely ethical precept—the correlative principles of beneficence and nonmaleficence. These must remain as the cornerstone of any new professional ethic. Without these ordering principles, no ethical restraint can be placed on the use of medical knowledge.

The other principle still viable in the *Oath* is competence. This is even more strongly enjoined in the Hippocratic treatises *Physician, Law, Decorum, On the Art, and On Ancient Medicine*. Competence, like beneficence, is "internal" to medicine as an activity. Without competence, none of the healing purposes of medicine can be achieved.

These principles must be enhanced by the virtue of altruism, especially noted in *Decorum*.<sup>39</sup> Together, they are essential if the physician is to serve the telos of medicine, which is healing. Additional virtues like honesty and tolerance, advised in the deontological books, complete that portion of the Hippocratic ethic that is still viable. The lesser virtues of calmness, a regular life, and decorous behavior referenced in the *Physician* and *Law* are important to the definition of the good

physician, but they are not as crucial as altruism, honesty, and tolerance.

Unfortunately, given the transformations in social mores, universal agreement among physicians on such fundamental tenets as the prohibitions against abortion, euthanasia, breaking confidentiality, and leading an "impure" life is not likely to be resuscitated. Many hold that these precepts are still valid, but henceforth we cannot expect sufficient agreement by the majority of physicians to include them in a common professional morality. To insist on such conformity is to divide the profession further and to make the task of reconstruction virtually impossible.

In the post-Hippocratic era, we must expect a two-part medical ethic. One part would consist of those precepts drawn from the nature of medicine to which all physicians might subscribe; the other part would vary depending upon fundamental philosophical and theological beliefs.

In designing the portion that will be common, we can draw on those parts of the Hippocratic corpus that are still viable. Some precepts will need to be modified, and others added. For example, we must retain the emphasis on beneficence but not the authoritarian strain of the *Oath*. Respect for the autonomy of the patient must be a clear commitment. We must think of the conflation of beneficence and autonomy so that they are not in conflict but mutually reinforcing. I would propose that we think of beneficence as held "in trust," responsive to the patient's wishes, while still motivated by a primary regard for his or her welfare.

### *The Addition of Missing Elements*

Any new professional ethic would have to include some of the following: (1) obligations to members of the health care team, (2) rejection of roles that conflict with the good of the patient, (3) a moral right of the physician to refuse to cooperate with a patient, institution, or policy that violates his or her own moral values, (4) a willingness under these conditions to withdraw from the care of the patient, (5) a moral right of the physician to the "discretionary space" necessary to act in the best interests of the patient lest this space be narrowed by legislation and law to the extent that the patient suffers, and (6) a commitment by the entire profession to act as the advocate for the best interests of the sick whenever and wherever those interests are threatened by law, economics, or social

convention. David Thomasma and I have recently proposed a set of commitments that we believe could form the basis for a generally accepted code of ethics suitable for the post-Hippocratic era.<sup>40</sup>

### **Conclusion**

The *Oath* and deontological writings of the Hippocratic corpus have formed the foundation of one of the most durable ethical codes in human history. The Hippocratic ethic has raised the moral sensitivities and constrained the behavior of physicians for centuries. Its prescriptions and proscriptions have united the world's physicians across religious, cultural, and national barriers. As a result, the care of the sick has entailed obligations of beneficence of the highest order.

In the last two decades, a series of social, economic, and political forces have converged to weaken this ancient edifice. Every element in the Hippocratic ethic is under scrutiny as a result. We can truly be said to be entering the post-Hippocratic era.

What this era portends for medical ethics and, more significantly, for the care of the sick is just becoming manifest. Public and profession alike have a stake in the outcome. Our task together is to examine what has been bequeathed to us by the past, to alter what cannot be morally justified, to retain what is morally viable, and to refashion a new edifice that neither discards all of the past nor accepts all of the new.

The post-Hippocratic era need not be viewed as the end of medical morality but as the beginning of an era of more responsible, more adult, more open, and more morally responsive relations between the sick and those who offer to help and heal them.

### **References**

1. Pellegrino ED. Toward a reconstruction of medical morality: the primacy of the act of profession and the fact of illness. *J Med Philos* 1979; 4:32-56.
2. Menon A, Haberman HF. Oath of initiation (from the Caraka Samhita). *Med Hist* 1970; 14:295-6. Reprinted in: Reich WT. *The encyclopedia of bioethics*. New York: Free Press, 1978:1732-3.
3. Veith I. *The yellow emperor's classic of internal medicine (Huang-ti nei ching)*. Berkeley: University of California Press, 1966.
4. Hippocrates. (*Oath, Physician, Precepts, Decorum, Law, On the Art, Ancient Medicine, Epidemics*.) Vol. 1-2. Translated by WHS Jones. Loeb Classical Library. Cambridge, MA: Harvard University Press, 1923-1931.
5. Temkin O, Temkin CL, eds. *Ancient medicine: se-*

- lected papers of L. Edelstein. Baltimore: Johns Hopkins University Press, 1967: 328-9.
6. Hippocrates. (Oath.) Vol. 1:299.
  7. *Idem.* (Epidemics.) Vol. 1:165.
  8. Pellegrino ED, Thomasma DC. For the patient's good: the restoration of beneficence in health care. New York: Oxford University Press, 1988.
  9. Hippocrates. (Oath.) Vol. 1:299.
  10. Final report of the Netherlands state committee on euthanasia: an English summary. *Bioethics* 1987; 1:163-74.
  11. Mathews J. Doctors admit euthanasia, group says. *New York Times*. February 26, 1988:A6.
  12. *Bouvia v Superior Court (Glenchur)*, 225 Cal. Rptr. 297 (1986).
  13. Bishop K. California euthanasia plan fails. *New York Times*. May 18, 1988:D30.
  14. Jones WHS. The doctor's oath: an essay on medicine. Cambridge, MA: Cambridge University Press, 1924.
  15. Temkin O, Temkin CL, eds. Ancient medicine, pp. 26-32.
  16. Black J. Pelvic therapy. *New Times* 1978; 2:52-6.
  17. Six percent of U.S. psychiatrists admit to sexual relations with patients. *Washington Post*, August 31, 1986: A9a.
  18. Hippocrates. (Oath.) Vol. 1:301.
  19. *Idem.* (Decorum.) Vol. 2:287.
  20. Guy PJ. AIDS: a doctor's duty. *Br Med J* 1987; 294:445.
  21. Clendinen D. Doctors in Georgia city strike back over suits. *New York Times*. May 14, 1986:A1a.
  22. Orthopedic surgeons and obstetricians at Mass. hospitals reject new patients. *Washington Post*. February 4, 1986:A5c.
  23. Davis JE. National initiatives for care of the medically needy. *JAMA* 1988; 259:3171-3.
  24. Lundberg GD. American medicine's problems, opportunities, and enemies. *JAMA* 1988; 259:3174.
  25. Pellegrino ED. Altruism, self-interest and medical ethics. *JAMA* 1987; 259:1939-40.
  26. Hippocrates. (Decorum.) Vol. 2:297-9.
  27. *Idem.* (The Art.) Vol. 2:201-3.
  28. Pellegrino ED. Rationing health care: the ethics of medical gate-keeping. *J Contemp Health Law Policy*. 1986; 2:23-45.
  29. Hippocrates. (Precepts.) Vol. 1:317-9.
  30. *Idem.* (Decorum.) Vol. 2:287.
  31. Hamilton E, Cairns H, eds. Collected dialogues of Plato. Bollinger Series. Princeton, NJ: Princeton University Press, 1961:341c-346.
  32. Lifton RJ. The Nazi doctors. New York: Basic Books, 1986.
  33. Bloch S, Reddaway P. Psychiatric terror: how Soviet psychiatry is used to suppress dissent. New York: Basic Books, 1977.
  34. Koryagin A. Unwilling patients. *Lancet* 1981; 1:821-4.
  35. British Medical Association. The torture report: a report of a working party of the British Medical Association investigating the involvement of doctors in torture. London: British Medical Association, 1986.
  36. Rayner M. Turning a blind eye? Medical accountability and the prevention of torture in South Africa. Washington, D.C.: AAAS, 1987.
  37. Sconocchia S, ed. *Scribonii Largi compositiones*. Leipzig: B.G. Teubner, 1983.
  38. Higgenbotham J, trans. On moral obligation: a new translation of Cicero's "De Officiis." London: Faber and Faber, 1967.
  39. Hippocrates. (Decorum.) Vol. 2:287.
  40. Pellegrino ED, Thomasma DC. For the patient's good, pp. 205-6.