Chapter 14
Toward an Expanded Medical Ethics:
The Hippocratic Ethic Revisited
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The Hippocratic ethic is one of the most admirable codes in the history of man... but even its ethical sensibilities and high moral tone are insufficient for the complexities of today's problems. ... An evolving, constantly refurbished system of medical ethics is requisite in the twentieth century.

MORE IS NEEDED

Custom without truth is but the seniority of error.
Saint Cyprian, Epistles LXXIV

The good physician is by the nature of his vocation called to practice his art within a framework of high moral sensitivity. For two millennia this sensitivity was provided by the Oath and the other ethical writings of the Hippocratic corpus. No code has been more influential in heightening the moral reflexes of ordinary men. Every subsequent medical code is essentially a footnote to the Hippocratic precepts, which even to this day remain the paradigm of how the good physician should behave.

The Hippocratic ethic is marked by a unique combination of humanistic concern and practical wisdom admirably suited to the physician's tasks in society. In a simpler world, that ethic long sufficed to guide the physician in his service to patient and community. Today, the intersections of medicine with contemporary science, technology, social organization, and changed human values have revealed significant missing dimensions in the ancient ethic. The reverence we rightly accord the Hippocratic precepts must not obscure the need for a critical examination of their missing dimensions—those most pertinent for contemporary physicians and society. The need for expanding traditional medical ethics is already well-established. It was first underscored by the shocking revelations of the Nuremberg trials. A spate of new codes has appeared which attempt to deal more responsibly with the promise and the dangers of human experimentation; the inquiry is well under way.1-3

More recently, further ethical inquiries have been initiated to reflect the change in moral climate and medical attitudes toward abortion, population control, euthanasia, transplanting...
organs, and manipulating human behavior and genetic constitution.1-5

In actual fact, some of the major proscriptions of the Hippocratic Oath are already being consciously compromised: confidentiality can be violated under certain conditions of law and public safety; abortion is being legalized; dangerous drugs are used everywhere; and a conscious but controlled invasion of the patient’s rights in human experimentation is now permitted.

This essay will examine some important dimensions of medical ethics not included in the Hippocratic ethic and, in some ways, even obscured by its too rigorous application. To be considered here are the ethics of participation, the questions raised by institutionalizing medical care, the need for an axiology of medical ethics, the changing ethics of competence, and the tensions between individual and social ethics.

An analysis of these questions will reveal the urgent need for expanding medical ethical concerns far beyond those traditionally observed. A deeper ethic of social and corporate responsibility is needed to guide the profession to levels of moral sensitivity more congruent with the expanded duties of the physician in contemporary culture.

THE HIPPOCRATIC ETHIC

The normative principles which constitute what may loosely be termed the Hippocratic ethic are contained in the Oath and the deontological books: Law, Decorum, Precepts, and The Physician. These treatises are of varied origin and combine behavioral imperatives derived from a variety of sources—the schools at Cos and Cnidus, intermingled with Pythagorean, Epicurean, and Stoic influences.6-7

The Oath8 speaks of the relationships of the student and his teacher, advises the physician never to harm the patient, enjoins confidentiality, and proscribes abortion, euthanasia, and the use of the knife. It forbids sexual commerce with the women in the household of the sick. The doctor is a member of a select brotherhood dedicated to the care of the sick, and his major reward is a good reputation.

Law discusses the qualities of mind and the diligence required of the prospective physician from early life.9 The Physician emphasizes the need for dignified comportment, a healthy body, a grave and kind mien, and a regular life.9(pp 311-313) In Decorum, we are shown the unique practical wisdom rooted in experience which is essential to good medicine and absent in the quack; proper comportment in the sick room dictates a reserved, authoritative, composed air; much practical advice is given on the arts and techniques of clinical medicine.9(pp 278-301) Precepts again warns against theorizing without fact, inveighs against quackery, urges consideration in setting fees, and encourages consultation in difficult cases.9(pp 215-325)

Similar admonitions can be found scattered throughout the Hippocratic corpus, but it is these few brief ethical treatises which have formed the character of the physician for so many centuries. From them, we can extract what can loosely be called the Hippocratic ethic—a mixture of high ideals, common sense, and practical wisdom. A few principles of genuine ethics are often repeated and intermingled with etiquette and homespun advice of all sorts. The good physician emerges as an authoritative and competent practitioner, devoted to his patient’s well-being. He is a benevolent and sole arbiter who knows what is best for the patient and makes all decisions for him.

There is in the Hippocratic corpus little explicit reference to the responsibilities of medicine as a corporate entity with responsibility for its members and duties to the greater human community. The ethic of the profession as a whole is assured largely by the moral behavior of its individual members. There is no explicit delineation of the corporate responsibility of physicians for one another’s ethical behavior. On the whole, the need for maintaining competence is indirectly stated. There are, in short, few explicit recommendations about what we would today call “social ethics.”
These characteristics of the Hippocratic ethic have been carried forward to our day. They are extended in the code of Thomas Percival, which formed the basis of the first code of ethics adopted by the American Medical Association in 1847. They were sufficient for the less complex societies of the ancient and modern worlds but not for the contemporary twentieth-century experience. The Hippocratic norms can no longer be regarded as unchanging absolutes but as partial statements of ideals, in need of constant reevaluation, amplification, and evolution.

Without in any way denigrating the essential worth of the Hippocratic ethic, it is increasingly apparent that the ideas conveyed about the physician are simplistic and incomplete for today’s needs. In some ways, it is even antipathetic to the social and political spirit of our times. For example, the notion of the physician as a benevolent and paternalistic figure who decides all for the patient is inconsistent with today’s educated public. It is surely incongruous in a democratic society in which the rights of self-determination are being assured by law. In a day when the remote effects of individual medical acts are so consequential, we cannot be satisfied with an ethic which is so inexplicit about social responsibilities. Nowhere in the Hippocratic Oath is the physician recognized as a member of a corporate entity which can accomplish good ends for man that are more than the sum of individual good acts. The necessity for a stringent ethic of competence and a new ethic of shared responsibility which flows from team and institutional medical care are understandably not addressed.

It is useful to examine some of these missing ethical dimensions as examples of the kind of organic development long overdue in professional medical ethical codes.

**THE ETHICS OF PARTICIPATION**

The central and most admirable feature of the Oath is the respect it inculcates for the patient. In the Oath, the doctor is pledged always to help the patient and keep him from harm. This duty is then exemplified by specific prohibitions against abortion, use of deadly drugs, surgery, breaches of confidence, and indulgence in sexual relations with members of the sick person’s household. Elsewhere, in *The Physician, Decorum, and Precepts*, the physician is further enjoined to be humble, careful in observation, calm and sober in thought and speech. These admonitions have the same validity today that they had centuries ago and are still much in need of cultivation.

But in one of these same works, *Decorum*, we find an excellent example of how drastically the relationship between physician and patient has changed since Hippocrates’ time. The doctor is advised to, “Perform all things calmly and adroitly, concealing most things from the patient while you are attending him.” A little further on, the physician is told to treat the patient with solicitude, “revealing nothing of the patient’s present and future condition.” This advice is at variance with social and political trends and with the desires of most educated patients. It is still too often the modus operandi of physicians dreaming of a simpler world in which authority and paternalistic benevolence were the order of the day.

Indeed, a major criticism of physicians today centers on this very question of disclosure of essential information. Many educated patients feel frustrated in their desire to participate in decisions which affect them as intimately as medical decisions invariably do. The matter really turns on establishing new bases for the patient’s trust. The knowledgeable patient can trust the physician only if he feels the latter is competent and uses that competence with integrity and for ends which have value for the patient. Today’s educated patient wants to understand what the physician...
Today's educated patient wants
to understand what the physician
is doing, why he is doing it, what
the alternatives may be, and what
choices are open.

is doing, why he is doing it, what the alternatives may be, and what choices are open. In a
democratic society, people expect the widest
protection of their rights to self-determination.
Hence, the contemporary patient has a right
to know the decisions involved in managing
his case.

When treatment is specific, with few choices
open, the prognosis good, and side effects
minimal, disclosing the essential information
is an easy matter. Unfortunately, medicine fre­
cently deals with indefinite diagnoses and
nonspecific treatments of uncertain value. Sev­
eral alternatives are usually open; prognosis
may not be altered by treatment; side effects
are often considerable and discomfort signifi­
cant. The patient certainly has the right
to know these data before therapeutic interven­
tions are initiated. The Nuremberg Code and
others were designed to protect the subject in
the course of human experimentation by in­
sisting on the right of informed and free con­
sent. The same right should be guaranteed in
the course of ordinary medical treatment as
well.

So fundamental is this right of self-deter­
mination in a democratic society that to limit
it, even in ordinary medical transactions, is to
propagate an injustice. This is not to ignore
the usual objections to disclosure: the fear of
inducing anxiety in the patient, the inability
of the sick patient to participate in the deci­
sion, the technical nature of medical know­
ledge, and the possibility of litigation. These
objections deserve serious consideration but
will, on close analysis, not justify concealment
except under special circumstances. Obviously,
the fear of indiscriminate disclosure cannot
obfuscate the invasion of a right, even when
concealment is in the interest of the patient.

Surely, the physician is expected by the pa­
tient and society to use disclosure prudently.
For the very ill, the very anxious, the poorly
educated, the too young, or the very old, he
will permit himself varying degrees of dis­
closure. The modes of doing so must be
adapted to the patient's educational level,
psychologic responses, and physiologic state.
It must be emphatically stated that the pur­
pose of disclosure of alternatives, costs, and
benefits in medical diagnosis and treatment is
not to relieve the physician of the onus of de­
cision or displace it on the patient. Rather, it
permits the physician to function as the tech­
nical expert and adviser, inviting the patient's
participation and understanding as aids in
the acceptance of the decision and its conse­
quences. This is the only basis for a mature,
just, and understandable physician-patient
relationship.

DEONTOLOGIC VERSUS
AXIOLOGIC ETHICS

The most important human reason for ena­
bling the patient to participate in the decisions
which affect him is to allow consideration of
his personal values. Here, the Hippocratic
tradition is explicitly lacking, since its spirit
is almost wholly deontological, that is, obliga­
tions are stated as absolutes without reference
to any theory of values. Underlying value sys­
tems are not stated or discussed. The need for
examining the intersection of values inherent
in every medical transaction is unrecognized.
The values of the physician or of medicine
are assumed to prevail as absolutes, and an
operational attitude of "noblesse oblige" is
encouraged.

A deontologic ethic was not inappropriate
for Greek medicine, which did not have to face
so many complex and antithetical courses of
action. But a relevant ethic for our times must
be more axiologic than deontologic, that is,
based in a more conscious theory of values.
The values upon which any action is based are
of enormous personal and social consequence.
An analysis of conflicting values underlies the
choice of a noxious treatment for a chronic illness, the question of prolonging life in an incurable disease, or setting priorities for using limited medical resources. Instead of absolute values, we deal more frequently with an intersection of several sets and subsets of values: those of the patient, the physician, sciences, and society. Which shall prevail when these values are in conflict? How do we decide?

The patient's values must be respected whenever possible and whenever they do not create injustice for others. The patient is free to delegate the decision to his physicians, but he must do this consciously and freely. To the extent that he is educated, responsible, and thoughtful, modern man will increasingly want the opportunity to examine relative values in each transaction. When the patient is unconscious or otherwise unable to participate, the physician or the family acts as his surrogate, charged as closely as possible to preserve his values.

The Hippocratic principle of *primum non nocere*, therefore, must be expanded to encompass the patient's value system if it is to have genuine meaning. To impose the doctor's value system is an intrusion on the patient; it may be harmful, unethical, and result in an error in diagnosis and treatment. Further, the concept of "health" as a positive entity is as vague today as in Hippocrates' time. Its definition is highly personal. The physician's view of health may be quite at variance with that of the patient or even of society. The doctor understandably tends to place an ideological value on health and medicine. Society should expect this from him as an expert, but his view must not prevail unchallenged. Indeed, society must set its own priorities for health. The amelioration of social disorders like alcoholism, sociopathy, drug addiction, and violence can have greater value for a healthy human existence, for example, than merely prolonging life in patients with chronic disabling disorders. Indeed, the patient and society now demand to participate in making the choices. The configuration of value choices each of us makes defines concretely our uniqueness and individuality. Hence, each patient has a slightly different definition of health. The physician is also a person with a set of values which invariably colors his professional acts. His views of sex, alcohol, suffering, poverty, race, and so forth can sharply differ with those of his patient. His advice on these matters, as well as his definition of cooperation, often have a strong ideologic or moralistic tinge. The physician must constantly guard against confusing his own values as the "good," to which all must subscribe if they desire to be treated by him.

Disclosure is, therefore, a necessary condition if we really respect each patient as a unique being whose values, as a part of his person, are no more to be violated than his body. The deontologic thrust of traditional medical ethics is too restrictive in a time when the reexamination of all values is universal. It even defeats the very purposes of the traditional ethic, which are to preserve the integrity of the patient as a person.

**INDIVIDUAL VERSUS SOCIAL ETHICS**

Another notably unexplored area in the Hippocratic ethic is the social responsibility of the physician. Its emphasis on the welfare of the individual patient is exemplary, and this is firmly explicated in the Oath and elsewhere. Indeed, in *Precepts*, this respect for the individual patient is placed at the very heart of medicine: "Where there is love of one's fellow man, there is love of the Art." *(p. 319)*

As Ford has shown, today too the physician's sense of responsibility is directed overwhelmingly toward his own patient.11 This is
one of the most admirable features of medicine, and it must always remain the central ethical imperative in medical transactions. But it must now be set in a context entirely alien to that in which ancient medicine was practiced. In earlier eras the remote effects of medical acts were of little concern, and the rights of the individual patient could be the exclusive and absolute base of the physician’s actions. Today, the growing interdependence of all humans and the effectiveness of medical techniques have drastically altered the simplistic arrangements of traditional ethics. The aggregate effects of individual medical acts have already changed the ecology of man. Every death prevented or life prolonged alters the number, kind, and distribution of human beings. The resultant competition for living space, food, and conveniences already imperils our hope for a life of satisfaction for all mankind.

Even more vexing questions in social ethics are posed when we attempt to allocate our resources among the many new possibilities for good inherent in medical progress and technology. Do we pool our limited resources and manpower to apply curative medicine to all now deprived of it or continue to multiply the complexity of services for the privileged? Do we apply mass prophylaxis against streptococcal diseases, or repair damaged valves with expensive heart surgery after they are damaged? Is it preferable to change cultural patterns in favor of a more reasonable diet for Americans or develop better surgical techniques for unplugging fat-occluded coronary arteries? Every health planner and concerned public official has his own set of similar questions. It is clear that we cannot have all these things simultaneously.

This dimension of ethics becomes even more immediate when we inquire into the responsibility of medicine for meeting the urgent sociomedical needs of large segments of our population. Can we absolve ourselves from responsibility for deficiencies in distribution, quality, and accessibility of even ordinary medical care for the poor, the uneducated and the disenfranchised? Do we direct our health care system to the care of the young in ghettos and underdeveloped countries or to the affluent aged? Which course will make for a better world? These are vexing questions of the utmost social concern. Physicians have an ethical responsibility to raise these questions and, in answering them, to work with the community in ordering its priorities to make optimal use of available medical skills.

It is not enough to hope that the good of the community will grow fortuitously out of the summation of good acts of each physician for his own patients. Societies are necessary to insure enrichment of the life of each of their members. But they are more than the aggregate of persons within them. As T. S. Eliot puts it, “What life have you if you have not life together? There is no life that is not in community.”

Society supports the doctor in the expectation that he will direct himself to socially relevant health problems, not just those he finds interesting or remunerative. The commitment to social egalitarianism demands a greater sensitivity to social ethics than is to be found in traditional codes. Section ten of the American Medical Association Principles of Medical Ethics (1946) explicitly recognizes the profession’s responsibility to society. But a more explicit analysis of the relationships of individual and social ethics should be undertaken. Medicine, which touches on the most human problems of both the individual and society, cannot serve man without attending to both his personal and communal needs.

This is not to say that medical codes or physicians are to set social priorities. Clearly, the individual physician cannot quantitate the remote effects of each of his medical acts. Nor should he desert his patients to devote himself entirely to social issues. He cannot withhold specific treatment in hope of preventing some future perturbation of human ecology. Nor can society relegate solely to physicians such policy questions as how and for whom the major health effort will be expended.

In these matters the physician serves best
as an expert witness, providing the basis for informed public decisions. He must lead in pointing out deficiencies and raising the painful matter of choices. At the same time, each doctor must honor his traditional contract to help his own patient. He cannot allow the larger social issues to undermine that solicitude. The ethically responsive doctor will thus find himself more and more at the intersection of social and individual ethical values, impelled to act responsibly in both spheres. The Hippocratic ethic and its later modifications were not required to confront such paradoxes. Today's conscientious physician is very much in need of an expanded ethic to cope with his double responsibility to the individual and to the community.

THE ETHICS OF INSTITUTIONALIZED MEDICINE

The institutionalization of all aspects of medical care is an established fact. With increasing frequency, the personal contract inherent in patient care is made with institutions, groups of physicians, or teams of health professionals. The patient now often expects the institution or group to select his physician or consultant and to assume responsibility for the quality and quantity of care provided.

Within the institution itself, the health care team is essential to the practice of comprehensive medicine. Physicians and nonphysicians now cooperate in providing the spectrum of special services made possible by modern technology. The responsibility for even the most intimate care of the patient is shared. Some of the most important clinical decisions are made by team members who may have no personal contact at all with the patient. The team itself is not a stable entity of unchanging composition. Its membership changes in response to the patient's needs, and so may its leadership. Preserving the traditional rights of the patient, formerly vested in a single identifiable physician, is now sometimes spread anonymously over a group. Competence, confidentiality, integrity, and personal concern are far more difficult to assure with a group of diverse professionals enjoying variable degrees of personal contact with the patient.

No current code of ethics fully defines how the traditional rights of the medical transaction are to be protected when responsibility is diffused within a team and an institution. Clearly, no health profession can elaborate such a code of team ethics by itself. We need a new medical ethic which permits the cooperative definition of normative guides to protect the person of the patient served by a group, none of whose members may have sole responsibility for care. Laymen, too, must participate, since boards of trustees set the overall policies which affect patient care. Few trustees truly recognize that they are the ethical and legal surrogates of society for the patients who come to their institutions seeking help.

Thus, the most delicate of the physician's responsibilities, protecting the patient's welfare, must now be fulfilled in a new and complicated context. Instead of the familiar one-to-one unique relationship, the physician finds himself coordinator of a team, sharing with others some of the most sensitive areas of patient care. The physician is still bound to see that group assessment and management are rational, safe, and personalized. He must especially guard against the dehumanization so easily and inadvertently perpetrated by a group in the name of efficiency.

The doctor must acquire new attitudes. Since ancient times, he has been the sole dominant and authoritarian figure in the care of his patient. He has been supported in this position by traditional ethics. In the clinical
emergency, his dominant role is still unchallenged, since he is well trained to make quick decisions in ambiguous situations. What he is not prepared for are the negotiations, analysis, and ultimate compromise fundamental to group efforts and essential in nonemergency situations. A whole new set of clinical perspectives must be introduced, perspectives difficult for the classically trained physician to accept, but necessary if the patient is to benefit from contemporary technology and organization of health care.

THE ETHICS OF COMPETENCE

A central aim of the Oath and other ethical treatises is to protect the patient and the profession from quackery and incompetence. In the main, competence is assumed as basic to fulfillment of the Hippocratic ideal of

prime non nocere. In places, more specific admonitions are to be found. Thus, in Law, "Medicine is the most distinguished of all the arts, but through the ignorance of those who practice it, and those who casually judge such practitioners, it is now of all arts by far the least esteemed." The author of this treatise thus succinctly expressed the same concerns being voiced at greater length and with more hyperbole in our own times. In the treatise on fractures, specific advice is given to prevent curable cases from becoming incurable, to choose the simpler treatment, to attempt to help, even if the patient seems incurable, and to avoid "unnecessary torment." Consultation is clearly advised in Precepts. In Decorum, frequent visits and careful examination are enjoined.

The Hippocratic works preach the wholly admirable common-sense ethos of the good artisan: careful work, maturation of skills, simplicity of approach, and knowledge of limitations. This was sound advice at a time when new discoveries were so often the product of speculation untainted by observation or experience. The speculative astringency of the Hippocratic ethic was a potent and necessary safeguard against the quackery of fanciful and dangerous "new" cures.

With the scientific era in medicine, the efficacy of new techniques and information in changing the natural history of disease was dramatically demonstrated. Today, the patient has a right to access to the vast stores of new knowledge useful to medicine. Failure of the physician to make this reservoir available and accessible is a moral failure. The ethos of the artisan, while still a necessary safeguard, is now far from being a sufficient one.

Maintaining competence today is a prime ethical challenge. Only the highest standard of initial and continuing professional proficiency is acceptable in a technological world. This imperative is now so essential a feature of the patient-physician transaction that the ancient mandate, "Do no harm," must be supplemented: "Do all things essential to optimal solution of the patient's problem." Anything less makes the doctor's professional declaration a sham and a scandal.

Competence now has a far wider definition than in ancient times. Not only must the physician encompass expertly the knowledge pertinent to his own field, but he must be the instrument for bringing all other knowledge to bear on his patient's needs. He now functions as one element in a vast matrix of consultants, technicians, apparatus, and institutions, all of which may contribute to his patient's well-being. He cannot provide all these things himself. To attempt to do so is to pursue the romantic and vanishing illusion of the physician as Renaissance man.

The enormous difficulties of its achievement notwithstanding, competence has become the first ethical precept for the modern physician after integrity. It is also the prime humane precept and the one most peculiar to the physician's function in society. Even the current justifiable demands of patients and medical students for greater compassion must not obfuscate the centrality of competence in the physician's existence. The simple intention to help others is commendable but, by itself, not
only insufficient but positively dangerous. What is more inhumane or more a violation of trust than incompetence? The consequence of a lack of compassion may be remediable, while a lack of competence may cost the patient his chance for recovery of life, function, and happiness. Clearly, medicine cannot attain the ethical eminence to which it is called without both compassion and competence.

Within this framework, a more rigorous ethic of competence must be elaborated. Continuing education, periodic recertification, and renewal of clinical privileges have become moral mandates, not just hopeful hortatory devices dependent upon individual physician responses. The Hippocratic ethic of the good artisan is now just the point of departure for the wide options technology holds out for individual and social health.

The one-to-one patient-to-physician relationship so earnestly extolled for centuries makes the patient almost totally dependent upon his physician for entry into the vast complex of potentially useful services. We cannot leave to fortune or statistics the possibility that the patient's choice of a physician might impede his access to all he needs for optimal care. We must surround this one-to-one relationship with the safeguards of a corporate responsibility in which the whole profession dedicates itself to protecting the patient's right to competent care.

TOWARD A CORPORATE ETHIC AND AN ETHICAL SYNCYTIUM

The whole of the Hippocratic corpus, including the ethical treatises, is the work of many authors writing in different historical periods. Thus, the ethical precepts cannot be considered the formal position of a profession in today's sense. There is no evidence of recognition of true corporate responsibility for larger social issues or of sanctions to deter miscreant members. Indeed, in Law, there is a clear lament for the lack of penalties to restrain or punish the unethical physician: "... medicine is the only art which our states have made subject to no penalty save that of dishonor. And dishonor does not wound those who are compacted of it." [p 263]

Again, in Precepts: "Now no harm would be done if bad practitioners received their due wages. But as it is, their innocent patients suffer, for whom the violence of their disorder did not appear sufficient without the addition of their physician's inexperience." [p 315]

The Greek physician seems to have regarded himself as the member of an informal aristocratic brotherhood, in which each individual was expected to act ethically and to do so for love of the profession and respect of the patient. His reward was doxa, a good reputation, which in turn assured a successful practice. There is notably no sense of the larger responsibilities as a profession for the behavior of each member. Nowhere stated are the potentialities and responsibilities of a group of high-minded individuals to effect reforms and achieve purposes transcending the interests of individual members. In short, the Greek medical profession relied on the sum total of individual ethical behaviors to assure the ethical behavior of the group.

This is still the dominant view of many physicians in the Western world who limit their ethical perspectives to their relationships with their own patients. Medical societies do censure unethical members with varying alacrity for the grosser forms of misconduct or breaches of professional etiquette. But there is as yet insufficient assumption of a corporate and shared responsibility for the actions of each member of the group. The power of physicians as a polity to effect reforms in quality of care, its organization, and its relevance to the needs of society is as yet unrealized.

Yet many of the dimensions of medical ethics touched upon in this essay can only be secured by the conscious assumption of a corporate responsibility on the part of all physicians for the final pertinence of their individual acts to promote better life for all. There is the need to develop, as it were, a
functioning ethical syncytium in which the actions of each physician would touch upon those of all physicians and in which it is clear that the ethical failings of each member would diminish the stature of every other physician to some degree. This syncytial framework is at variance with the traditional notion that each physician acts as an individual and is primarily responsible only to himself and his patient.

This shift of emphasis is dictated by the metamorphosis of all professions in our complex, highly organized, highly integrated, and egalitarian social order. For most of its history medicine has existed as a select and loosely organized brotherhood. For the past hundred years in our country, it has been more formally organized in the American Medical Association and countless other professional organizations dedicated to a high order of individual ethics. A new stage in the evolution of medicine as a profession is about to begin as a consequence of three clear trends.

First, all professions are increasingly being regarded as services, even as public utilities, dedicated to fulfilling specific social needs not entirely defined by the profession. Professions themselves will acquire dignity and standing in the future, not so much from the tasks they perform, but from the intimacy of the connection between those tasks and the social life of which the profession is a part. Second, the professions are being democratized, and it will be ever more difficult for any group to hold a privileged position. The automatic primacy of medicine is being challenged by the other health professions, whose functions are of increasing importance in patient care. This functionalization of the professions tends to emphasize what is done for a patient and not who does it. Moreover, many tasks formerly performed only by the physicians are now being done by other professionals and nonprofessionals. Last, the socialization of all mankind affects the professions as well. Hence, the collectivity will increasingly be expected to take responsibility for how well or poorly the profession carries out the purposes for which it is supported by society.

These changes will threaten medicine only if physicians hold to a simplistic ethic in which the agony of choices among individual and social values is dismissed as spurious or imaginary. The physician is the most highly educated of health professionals. He should be first to take on the burdens of a continuing self-reformation in terms of a new ethos—one in which the problematics of priorities and values are openly faced as common responsibilities of the entire profession. We must recognize the continuing validity of traditional ethics for the personal dimensions of patient care and their inadequacy for the newer social dimensions of health in contemporary life. It is the failure to appreciate this distinction that stimulates so much criticism of the profession at the same time that individual physicians are highly respected.

PROBLEMS AND RESPONSIBILITIES What are some of the ethical problems and social responsibilities which are best assured by a corporate posture? We mention but a few as examples, especially those outlined earlier in this essay.

ASSURING COMPETENCE In a technical society with knowledge increasing exponentially, all members of a profession cannot attain the same degree of competence. The whole body of physicians must assume responsibility for guaranteeing to society the highest possible competence in each member. A most effective way to assure this is for each professional group to require, as some already have, the periodic demonstration of continued proficiency as a first condition for continuing membership in the profession. Physicians should take leadership in requiring relicensure and recertification, set the standards of performance, and insist on a remedial and not a punitive approach for those who need refurbishment of their knowledge to qualify for recertification. Implicit in this idea is the possibility that at some point each of us may
fail to qualify for reasons such as age, illness, or loss of interest. A profession sensitive to its ethical responsibilities cannot tolerate fading competence, even for reasons beyond the physician's control. Instead, it must provide opportunities for remediation or for alternate, more suitable functions within medicine. Surely, the wide range of uses of a medical education will assure a useful place for almost all physicians.

A most potent way to assure competence is to insist that all physicians practice within a context of competent colleagues and peer surveillance. It is an ethical responsibility of the whole profession to see that every licensed physician is a member of a hospital staff. The privilege of using a hospital is primarily a privilege for the patient, not the doctor. To deprive any licensed physician, because of training, economics, race, or other reasons, of hospital privilege is to deprive his patient and to perpetrate a social injustice. We also thereby lose the best chance to help the physician improve himself by contact with his colleagues and with institutional standards, as well as the informal network of teaching that links physicians together when they can discuss their cases with one another. No rationalization based on economics or professional prerogatives can excuse our profession from its ethical responsibility to enable every practitioner to participate in the mainstream of medical care, in the hospital and the medical school as well. This responsibility should extend to the osteopathic, as well as the allopathic, physician.

Once every physician is on a hospital staff, there is much the profession can do to develop a context within which competence becomes a value of prime importance. Some institutional mechanisms for review of certain aspects of competence already exist in tissue and utilization committees, though these first steps are not universally applied with sufficient vigor. A well-functioning drug information center in every hospital, a rigorous pharmacy and therapeutics committee, critical reviews of diagnostic accuracy and work-up, comparison of practices against national standards—these are examples of further institutional devices we should insist upon as ethical imperatives. Ultimately, each physician should have available for his own edification a computerized record of his diagnostic acumen, therapeutic practices, complications, and autopsy correlations. The essential matter is not the specific mechanisms used, but acceptance of the dictum that the competence of each member of the group is, in some real sense, the responsibility of all.

These measures can easily be discounted as repressive, regimentalizing infringements of professional freedom. Or, in a more enlightened ethical view, they can be the practical expression of corporate acceptance of the necessity of workable mechanisms to ensure competence in a technological society. Is there a real ethical choice? The patient, after all, has no means whereby he can judge the competence of the services rendered. Individual physicians and the profession owe the patient every possible safeguard. When these are not forthcoming, they will be imposed by a public demanding more accountability in medicine and every other sphere of life.

One of the gravest and most easily visible social inequities today is the maldistribution of medical services among portions of our population. This is another sphere in which the profession as a whole must assume respon-
sibility for what individual physicians cannot do alone. The civil rights movement and the revolt of the black and minority populations have punctuated the problem. Individual physicians have always tried to redress this evil, some in heroic ways. Now, however, the problem is a major ethical responsibility for the whole profession; we cannot dismiss the issue. We must engender a feeling of ethical diminution of the entire profession whenever there are segments of the population without adequate and accessible medical care. This extends to the provision of primary care for all, insistence on a system of coverage for all communities every hour of the day, proper distribution of the various medical specialties and facilities, and a system of fees no longer based on the usual imponderables, but on more standardized norms.

Fulfilling such ethical imperatives is sure to cause discomfort for the doctor, as well as some loss of privileges and even of remuneration. But unless there is corporate concern translated into corporate action and self-imposed responsibilities, restrictive legislation to achieve these ends seems certain. To an ethically perceptive profession, such legislation should not only be unnecessary, it should be a scandal. It is intrinsic to the very purposes of medicine that physicians exhibit the greatest sensitivity to any social injustice directly related to their mandate in society. The lack of this corporate sensitivity has been acutely perceived by some of today's students and has seriously disaffected them with medical education and practice.14 We hope, when they assume leadership of the profession, that they will feel these ethical discontinuities as clearly as they do now. If tomorrow's physicians practice what they now preach to their elders, they will indeed expand the ethical responsibilities of our profession into new and essential dimensions. To do so, they will need to supplement traditional medical ethics with a corporate ethical sense as we have just described it.

There are, perforce, reasonable limits to the social ills to which the individual physician and the profession can be expected to attend qua physician. Some have suggested that medicine concern itself with the Vietnam war, the root causes of poverty, environmental pollution, drugs, housing, and racial injustice. It would be difficult to argue that all of these social ills are primary ethical responsibilities of individual physicians or even of the profession. To do so would hopelessly diffuse medical energies and manpower from their proper object—the promotion of health and the cure of illness. The profession can fight poverty, injustice, and war through medicine.

A distinction, therefore, must clearly be made between the physician's primary ethical responsibilities, which derive from the nature of his profession, and those which do not. Each physician must strike for himself an optimal balance between professional and civic responsibilities. This will depend upon his energy, capabilities, the nature of his specialty, his family responsibilities, and other factors. The extremes of this choice are dangerous: a narrowly technical life, or a free-floating social concern which at best is neurotic and ineffectual and at worst can seriously compromise competence. Ever present is the seductive hubris to which physicians are especially susceptible—the assumption of some special authority or capability in the resolution of all social issues.

**THE ORDER OF ETHICAL RESPONSIBILITY**

It becomes a matter of prime ethical concern for each physician consciously to establish some hierarchy of values and priorities which...
will define his individual and social ethical postures. The ethical responsibilities of the professional group should be broad; those of the individual may of necessity be narrow. Is there some reasonable order of values in the maze of conflicting duties thrust upon physicians today? We will examine this question from the point of view of the clinician.

Surely, the first order of responsibility for clinicians must remain with the patients he undertakes to treat. Here, the moral imperatives are clear: competence of the highest order; integrity; compassion. These are contained in traditional medical ethics and can be made more relevant to our times by extension in some of the directions indicated earlier in this essay. To fail in this realm is to violate the trust underlying the personal relationship which characterizes medical care. Nothing is more unconscionable or socially unacceptable.

Only when this first order of ethical requirements has been met may the individual physician address himself to a second order of responsibilities. These are generally of two kinds: those which arise from medical progress—like human experimentation and genetic and behavioral modification—and those which bear directly on the condition of life of the community—population control, eradicating malnutrition, assurance of accessibility, comprehensive health care for all citizens, abortion, drugs, and so on. Of the two sets, the latter are more directly related to the daily work of the practitioner and pose ethical issues of an immediate nature, since they flow so directly from his first-order responsibilities.

In these matters, the physician can indeed act as a leader, a sensor of unmet needs, and an expert witness in constructing feasible solutions. He can mobilize his county and state society to assume corporate responsibility for distributing physicians, for mandating coverage of all communities, perhaps experimenting with use of nonphysicians. The physician can use his authority as a clinician to underline needs for improvement of services and facilities in his community. If he clearly focuses on patient and community health and not on his own prerogatives, there can be no more effective voice in initiating reforms.

The third order of responsibilities—those more properly related to the physician as a citizen than as a physician—are among the most crucial for modern man. Yet they are usually outside the physician’s prerogatives and distant from his direct function in society. Important as they are, these issues—poverty, war, racism—require knowledge the doctor must acquire. If these are his major concerns, he should make no pretense at also being a clinician, or he will become one in the most limited sense. Medical education and experience make a legitimate base for service in new fields or social and political action, but they do not legitimize the neglect of clinical competence in individual medical acts. This distinction needs careful scrutiny by those who would have the physician cure the accumulated social ills of our times and who upbraid him for his failures to do this and to maintain professional competence as well. “If you try to act beyond your powers, you not only disgrace yourself in it, but you neglect the part which you could have filled with success.”

THE INTERPLAY OF INDIVIDUAL AND CORPORATE ETHICS

The individual physician can, and indeed should, limit his ethical pretensions. The profession as a body can but should not. Physicians as a group must assume ethical responsibility for all three orders of responsibility which may bind each physician. The profession, as we have shown, must attempt to do as a body what individuals cannot do by themselves—namely, span the full range of ethical imperatives. The profession is bound to assume responsibility for the ethical behavior of its members, for setting the context which best guarantees good behavior and taking sanctions against members who fall from their high estate, while at the same time effecting their rehabilitation. Physicians as individuals
may eschew certain responsibilities as inappropriate, but the profession cannot.

Herein, then, lies the final guarantee for the patient and the community: the interplay of ethical responsibilities for each individual physician and of the whole body of physicians. Each physician must consciously define on several levels his personal moral responsibilities. The profession simultaneously must call for deep involvement of its members at all levels of ethical responsibility—the individual clinical medical transaction, the social consequences of medical acts and medical progress, the quality and availability of medical services, and the duties of its educated group to engage in the larger social issues confronting contemporary man. This reinforcement of the ethical perspective of the individual physician by a heightened ethical perception of the community of physicians is an essential ingredient of any professional ethical framework which hopes to cope with the current flux in values and goals afflicting modern society.

ETHICAL TENSIONS IN AN EXPANDED ETHIC

What will happen to the conscience and the values of the individual physician if the claims of society and the profession are given new ethical force? The law can insist that confidences be revealed in the interest of justice; if abortion is legalized, the physician as agent of society will be expected to provide this service; the same is true if euthanasia, personality and behavioral modification, and chemical sterilization should become public mandates. How shall we balance social and public mandates against the conscience of the individual physician? How will we safeguard the integrity of the physician’s own values?

We have a terrifying example of the inability of physicians to withstand social pressures in the acts of unmitigated evil perpetrated by the physicians in German prison camps. These physicians abdicated conscience and choice so thoroughly that they participated in the most reprehensible acts—convinced that they were innocent bystanders. The individual conscience simply ceased to exist, and the individual physician became a mindless cipher. They were willingly conscripted into that “auxiliary bureaucracy” which Gabriel Marcel so scathingly deplores in Man Against Mass Society.16

The very horror of this possibility should underscore how essential is the defense of the mind, conscience, and values of the individual physician and his patient in any system of medicine, ethics, or political organization. This is all the more reason for an axiologic approach, which always calls for an orderly analysis of the values underlying moral choices. The highest ethical call is still that of the conscience of an individual human person, a conscience which must be prepared at all times to take issue with social directives, corporate agreements, and political pressures. The dignity and the worth of the human being he treats must still remain the beacon that guides the physician’s conscience in the ethical night before us. Marcel pinpoints this duty so peculiar to our times: “It is within the scope of each of us, within his own proper field, in his profession, to pursue an unrelenting struggle for man, for the dignity of man against everything that today threatens to annihilate man and his dignity.” 16(p 211)

SUMMARY

We have attempted a brief analysis of some of the limitations and omissions in traditional medical ethics as embodied in the Hippocratic corpus and its later exemplifications. These limitations are largely in the realm of social and corporate ethics, realms of increasing significance in an egalitarian, highly structured, and exquisitely interlocked social order.

The individual physician needs more explicit guidelines than traditional codes afford to meet today’s new problems. The Hippocratic ethic is one of the most admirable codes in the history of man. But even its ethical
sensibilities and high moral tone are insufficient for the complexities of today’s problems.

An evolving, constantly refurbished system of medical ethics is requisite in the twentieth century. An axiologic, rather than a deontologic, bias is more in harmony with the questions raised in a world society whose values are in continual flux and reexamination. There is ample opportunity for a critical reappraisal of the Hippocratic ethic and for the elaboration of a fuller and more comprehensive medical ethic suited to our profession as it nears the twenty-first century. This fuller ethic will build upon the noble precepts set forth so long ago in the Hippocratic corpus. It will explicate, complement, and develop those precepts, but it must not be delimited in its evolution by an unwarranted reluctance to question even so ancient and honorable a code as that of the Hippocratic writings.

REFERENCES