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The Hippocratic Thorn in Bioethics' Hide: Cults, Sects, and Strangeness

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Bioethicists have typically disdained where they did not simply ignore the Hippocratic tradition in medicine. Its exclusivity—an oath of and for physicians—seemed contrary to the perspective that bioethicists have attempted to invoke. Robert M. Veatch recently articulated this rejection of the Hippocratic tradition, and of a professional ethic of medicine in general, in a volume based on his Gifford lectures. Here that argument is critiqued. The strengths of the Hippocratic tradition as a flexible and ethical social doctrine are offered in its stead.

Keywords: *covenant, Hippocrates, Hippocratic Oath, medical ethics, professional ethics, Robert Veatch*

I. INTRODUCTION

Beginning in 1966, China's Red Guards, engaged in The Great Proletarian Cultural Revolution, rampaged against the "four olds": old customs, old culture, old habits, and old ideas. The goal was to stamp out bourgeois "old thinking" ("jiù sīxiǎng" was one of the phrases for "old thinking") and institute a new populist culture and ethos. Chaos and disorder were the perhaps inevitable result.

In the 1970s, bioethics was born with a similar if more limited mission, the replacement of "old thinking" in medical ethics and research. It promised a new ethical order whose universal, canonical values would be grounded in an enlightened application of moral philosophy fashioned to fit the necessities of postwar medicine in an advancing technological society (Engelhardt, 2011, 244). Where the Cultural Revolution is remembered as an abysmal failure at every level, bioethics is presented, today, as an at least qualified success.

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Central to the bioethical revolution was a rejection of traditional medical ethics as an untenable guide to ethical practice in contemporary medicine. This was explicit in what Howard Brody has called the "Georgetown Mantra" in which what were assumed to be new dilemmas resulted from technological advances. Axiomatically, these would require a new ethic to permit their resolution (Brody, 2009, 212). The Mantra, Brody says, was shorthand for the bioethical clarion call of Tom Beauchamp and James Childress's landmark *Principles of Biomedical Ethics*. On page one it dismissed without consideration traditional medical ethics as a "rich storehouse of reflection" that was "inadequate for bioethics" in an advancing, postmodern, liberal democratic society (Beauchamp and Childress, 2001, 1). A new ethic based on "philosophical reflection" was advanced as a corrective for the old thinking.

Implicitly, this demanded that bioethicists reject the Hippocratic *Oath,* which, for millennia, stood as the ethical center of moral medical practice by defining the general relationship between physicians and patients in the society they shared. Were *The Oath* to stand unchallenged, bioethics would be at best a modern addendum to the "rich storehouse" of accumulated ethical and moral wisdom governing the physician's traditional, Hippocratic role in society. That, bioethics' progenitors insisted, would never serve.

This rejection of old thinking was largely axiomatic and declarative, presented without serious consideration of what the Hippocratic ethic was and how it functioned, historically and into the present age. Recently, Robert M. Veatch used his position as a Gifford lecturer to correct this oversight and to condemn the "old thoughts" of the Hippocratic ethic to the dung heap of moral histories (Veatch, 2012).

The publication of those lectures in 2012 was a significant service. Whereas earlier writers had dismissed reflexively the traditional ethic of medicine, assuming its inadequacy, Veatch attempted a serious critique of the Hippocratic legacy. The author and the context—the prestigious Gifford lectures—are significant. Veatch is an early and important member of the philosophical cadre that has long labored in bioethics' cultural revolution to banish old thoughts from the contemporary world of medical ethics. In the 1970s he was an early and active philosopher-ethicist at The Hastings Center where he was delegated to assist deliberations at the US Senate Health Committee, testifying for and assisting in what would become *The Belmont Report* (Veatch, 2012, 156–57). And, he was a member of the Center's "Death and Dying" research group that was active in arguing, for example, the case of Karen Ann Quinlin. Daniel Callahan, cofounder and long-time president of the Center, recently described Veatch as his "splendid and prolific" colleague (Callahan, 2012, 63). Since the 1970s, Veatch has certainly been prolific and stands as a central figure in bioethical writing (Veatch is an author or editor of over forty books) and teaching.

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II. HIPPOCRATES

Hippocrates of Coen is the name we give to the author of the Hippocratic corpus of writings that defined the school of medicine that bears his name. We know very little about this 400 B.C.E. physician except that the school of medicine he founded served as a foundation for Western medical thinking and practice for millennia. It was at once environmental (*Airs, Waters, and Places),* social (*The Oath*), and technical (Hippocrates, 1994 [400 BCE]). The corpus provided both a theory of disease and a complete description of diagnostics and treatment (through a series of texts such as "On Fistulas," "On Fractures," "On Injuries of the Head," "The Book of Prognostics," etc.).

The Hippocratic school was not, as Veatch insists, "an ancient Greek cult" but instead a complete system of medicine and social practice that triumphed over competing systems to create the bedrock of Western medical theory as it developed into the twentieth century. None of this is relevant to Veatch's central concern, however, or to the work of most bioethicists whose personal activities stop at the door of medical practice. The issue for Veatch, and others, is not Hippocratic medicine in general, but the 363-word Hippocratic *Oath* that, across history, has been recited either when a student began or completed his or her medical studies. It is *The Oath* that is the target of Veatch's and bioethics' distress.

The Oath consists of a preamble section calling upon a pantheon of Greek gods as witness of the physician's sincerity, a second section defining relations between physicians, and a third section describing the physician's responsibility to patients as a primary duty. It concludes with the statement that those who live by *The Oath* ("While I continue to keep this Oath unviolated")—respecting colleagues and practicing for the benefit of the patient—will be granted the joy of practice and the respect of all men.

Over time, some of the duties of members of the Hippocratic tradition to each other were ignored (e.g., the promise to teach their teacher's children without charge). They became obligations incompatible with the culture of medical training in different societies and times. The essence of *The Oath*, however, and the source of bioethical ire, remained constant. It is, in essence, a social covenant that defines medicine's goal as the care of the patient: "I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous." This promise—to put the patient's care first—was inviolate: "Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption."

The famous phrase *primum non nocere* ("First, do no harm") is not in *The Oath* but was derived later to summarize injunctions limiting practices dangerous to the patients. These included not operating on patients with "stones," to "give no deadly medicine," and to not prescribe a "pessary" to

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induce abortion. The injunction against surgeries for stones (gall or bladder) was a prohibition against techniques outside the average Hippocratic physician's training. It thus was rather like saying, today, that a general practitioner should not attempt neurosurgery. The injunction against dispersing deadly drugs was an injunction to preserve the life of citizens even if requested to do otherwise. The rejection of a pessary was in accord with social values promoting and protecting life. In all this *The Oath* was clear in its description of the physician's central obligation to preserve life and to promote the life and health of the patient in the community.

Greek society did not embrace the concept of the discrete citizen irreducibly distinct from all others but, instead, advanced the idea of a communal society in which the citizen and the community were conjoined. It was not that independent thought and action were unthinkable, but that the person was seen as indivisibly social, a person *in* community. It was this, Peter Singer notes, that made Socrates so radical and so challenging to Greek authorities (Singer, 1983, 21). Seen from this perspective, the Hippocratic injunction to patient care was also an injunction to social care. The person was the indivisible stock of society, and in insisting on the primacy of his or her health the Hippocratic physician simultaneously served society at large. Thus *The Oath* becomes a statement regarding the physician's obligation to both the citizens of the community and, through their maintenance, the value of the lives of those citizens in society.

The Oath's injunction to patient care as a primary medical duty and responsibility remains a tenet in most Western societies today. As Veatch notes unhappily (Veatch, 2012, 2–3), the American Medical Association's (AMA's) Code of Ethics begins with a reference to *The Oath* as a "living statement of ideals to be cherished by the physician" (American Medical Association, 2010, xiii). The British Medical Association's ethical code carries a similar passage. In the 1950s, the World Medical Association's (WMA's) Declaration of Geneva embraced the Hippocratic insistence that the first obligation for physicians in its member countries was to the health of the patient (World Medical Association, 1956, 10–12). That affirmation was seen as necessary in light of the co-option of medical personnel during the Third Reich in Germany and the use of patients as research objects there and elsewhere. For Veatch, however, the WMA restatement of the Hippocratic ideal was at best unfortunate and certainly wrong headed (Veatch, 2012, 62–63).

The resurgence of Hippocratic ethical direction was not limited to officialdom. Evocation of this "bizarre ethical theory" (Veatch, 2012, 27–28) promoting the primacy of the patient's life and health *increased* in medical schools in the second half of the twentieth century. Although fewer than twenty percent of all North American medical schools used *The Oath* early in the century, by 1993 it was recited, Veatch laments, in one or another form, by over ninety-eight percent of all schools surveyed. That is, as bioethics' new guard advanced, sweeping away old thoughts about medical

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ethics, the centerpiece of that old thinking—*The Oath*—gained in popularity. This is clearly problematic for those who insist the old ethics is wanting and the new bioethic must serve as an exclusive framework for the ethical practice of medicine.

Veatch insists, "any plausible religious or secular medical ethical system must stand in inevitable conflict with the ethics that derives from the Hippocratic Oath" (Veatch, 2012, 2). Yet, *The Oath* has been and is today being sworn by medical students of a range of religious persuasions (agnostic, Christian, Jewish, Islamic, Muslim, etc.) in a number of countries with differing social systems. This is, for Veatch, both inexplicable and frustrating. *The Oath*, in his reading, is, after all, no more than a remnant of a "pagan Greek religion that should offend the practitioner as well as the patient of any modern religious or secular persuasion" (Veatch, 2012, 12). And yet . . . it does not offend anyone but Veatch and, perhaps, a small cadre of similarly persuaded bioethicists.

If the suggestion is that *The Oath* should be rejected because of its religious grounding then, for the sake of consistency, we would have to reject use of the Caduceus as a medical symbol because it is also derived from Greek religious mythologies (Koch, 2012, 31–36). The enduring use of *The Oath* by centuries of students from a variety of religious backgrounds attests to the fact that it is not generally perceived as a religious document and at least since the beginning of the Christian era has not been seen as such. Swearing *by* the Greek gods is different from swearing *to* them. It is a way of saying "by all that is holy," and thus for centuries the preamble was recited without complaint long after belief in "Apollo the physician, Aesculapius, Health, and All-Heal" had faded. Various modern versions of *The Oath* in use today substitute other, more general evocations of sincerity without inflicting violence on the essential nature of *The Oath* or its relevance to practice and practitioners serving patients.

III. THE PATIENT AND SOCIETY

In the end, the religiosity of *The Oath* is a decidedly secondary straw man. Veatch's main complaint, what he and some other bioethicists find truly insupportable, is that "[t]he Hippocratic principle of benefiting the patient ignores the possibility of a social ethics in which physicians may have the right or duty to sacrifice their patients for the good of others in society" (Veatch, 2012, 14). An ethic insisting on the primacy of the patient's care and health may in some cases inconveniently stand as a barrier to this or that goal of this or that society. And for at least the old guard of the bioethical revolution, "medicine should therefore serve not the individual," as Daniel Callahan once put it, but "first and foremost serve the needs of the state" (Callahan, 1990, 253).

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Over the last century, there have been numerous instances when social goals imagined by this or that state official took precedence over *The Oath*'s insistence on the primacy of patient care. Time and again, sacrificing that focus at the altar of official priorities has proven ethically and morally disastrous. In a very partial list, for example, there were the medical termination of "defective" infants in the early part of the twentieth century (Pernick, 1996, 94–98), the involuntary sterilization of hundreds if not thousands of "idiot" women on the basis of state economics (*Buck v. Bell* 1927), and, of course, the termination of tens of thousands of persons with chronic diseases as costly nonworkers in Germany during the Third Reich (Burstyn, 1993, 15). It was at least in part in reaction to these ethical and moral violations—and especially those of the Third Reich in Germany—that in the postwar period the AMA and WMA returned to the Hippocratic emphasis.

Physicians failing to adhere to Hippocratic ideals have been complicit in a series of research programs that in retrospect may have been useful scientifically but were later perceived as severe violations of a broader social (and in some cases legal) code and its concomitant ethic. Here we might include, in a short American list, the failure to treat Tuskegee syphilis patients to promote studies of the progression of the disease (Russert, 2009, 155–71), introducing hepatitis to fragile children at Willowbrook Hospital for the same reason (Lysaught, 2009, 385), and inoculating poor women with HeLa cancer cells at Sloan-Kettering in New York to determine if the cells were in fact potent (the women were told it was a "test" for cancer) (Skloot, 2011, 129–30). If one takes Veatch seriously, physicians engaged in these and similar acts were blameless as long as their actions were at the bequest of state officials or at least carried out with their approval.

IV. RESEARCH

From its beginnings, bioethics has sought to promote the primacy of research over the immediate needs of the patient. This began with *The Belmont Report*, whose goal was to create an environment that would assuage citizen concerns—based on the then-recent, publicly condemned research inequities—and so create a social environment amenable to drug testing and subsequent product production (Koch, 2012, 124–26). That required distinguishing between the patient in care and the person whose illness made him or her a suitable research object. In this distinction *Belmont*, and the bioethical thinking based on it, thus promoted future production over the immediate needs of the person from the beginning. As Lysaught has argued, the goal from the start has been, first and foremost, the production of "docile bodies" in a system promoting research over the needs and preferences of the patient (Lysaught, 2009, 392–93).

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The result has been an essential conflict at the heart of the new thinking bioethics has sought to promote. Although it was in theory an ethic designed to advance patient autonomy and choice as a primary good, its central focus has been the promotion of research as a primary good with patient care as a decidedly secondary interest. The result is objectifying, making individual patients into research objects. The goal, as it was for US Supreme Court Justice Oliver Wendell Holmes in *Buck v. Bell*, is the economic health of the state rather than the physical and psychological health of the patient (*Buck v. Bell* 1927).

It is therefore not surprising that cost containment at the expense of patient care has become a common and perhaps dominant theme in modern bioethics (Callahan, 1987). Nor is it surprising that research necessities are argued as a primary goal rather than individual choice. In 2005, for example, Rosamond Rhodes and David Orenthlicher separately advanced the thesis that we might and should demand that all citizens's participate in medical research programs, preserving their right of choice perhaps to the selection of programs requiring test objects (Rhodes, 2005; Orenthlicher, 2005). And although *The Belmont Report* argued for a distinction between patient care and research—seeking to consider and promote only the latter—more recently bioethics has sought to obliterate that distinction.

In this new "learning system" patients in effect are defined as research subjects from the start (Faden et al., 2013). Although proponents argue for a continuing "respect for persons," it is hard to believe that that injunction is any more than window dressing in a system that makes research into unproven protocols an indivisible part of patient treatment. As Jill Fisher wrote of this trend, "The question becomes how coordinators ever justify enrolling patient-subjects in clinical trials when effective treatments are available for standard medical care" (Fisher, 2009, 87). Under this new bioethic nobody would have to justify anything, as long as accepted research protocols were observed, because the patient will be by definition a research object. His or her illness will be not a thing to be treated so much as a research opportunity. Treatment is a secondary goal; it is nice when it happens but not a principal focus of ethical or professional concern. No better example of this Veatchian trend can be rendered than the mandatory testing of newborn children for a range of genetic conditions for which no treatment exists. The goal is not care or treatment but principally the identification of subjects for future research and testing (President's Council on Bioethics, 2008).

V. THE PHYSICIAN

This is a relatively new perspective. Into the twentieth century, the primacy of patient duty enshrined in *The Oath* has been a bulwark against the

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transformation of patients into research objects. "We have no right," wrote William Osler in 1907, "to use patients entrusted to our care for the purpose of experimentation unless direct benefit of the individual is likely to follow" (Bliss, 1999, 352–53). To believe otherwise was to be in violation of the long tradition of Hippocratic medicine that stood as a bulwark, sometimes, against prevailing economic goals, research demands, and social requirements. That does not mean research was stymied, only that its pace was dictated by the needs of the patient.

It is in opposition to that Oslerian perspective that Veatch, and many other bioethicists, take a stand against the Hippocratic Oath. In arguing the case they degrade medicine to a technical affair whose practitioners should be barred from participating in the formulation of medically related social policies. "All the knowledge in the world about the facts of medicine cannot give one a special expertise," Veatch writes, "in making evaluative choices based on these facts" (Veatch, 2012, 25).

This is a curious argument when advanced by those who insist on the state's policies as the principal measure of appropriate behavior. After all, in law and society physicians are enjoined to act first and foremost in the interest of the patient regardless of the demands of officials or the needs of researchers. This is the Nuremberg principle formulated during the trial of German physicians who, at the direction of and with the blessings of state officials, experimented on prisoners during World War II (United Nations International Law Commission, 1950).

Physicians are not merely "craftsmen" or "professionals" who manufacture furniture or write sales agreements. They are active participants in the life and welfare of persons in society. As such, they are assumed to be ethical persons vocationally concerned with the care of persons who are citizens in society. When things go wrong, it is the physician who is held responsible by patients, their families, and society through its laws. At Tuskegee, Willowbrook, and Sloan-Kettering the physicians were the ones held responsible for detrimentally using patients as research objects. This is an ethical fact—ethics are about responsibilities to others—apparently lost on Veatch and others holding views similar to his.

We hold physicians morally responsible in a way that we do not hold responsible the carpenter who makes cheap furniture at the directions of the floor manager, or the automobile mechanic who puts together a defective engine, because we believe as a society that people are not simply objects. Because we believe in the value of individual persons, and thus their care as a primary good, we accept the virtue of the Hippocratic *Oath* that places the physician's duty to the patient before all other imperatives. Because we believe, with Kant, those persons should be seen as ends, not means, we insist that their care and maintenance be placed before their potential utility for research. We hold physicians individually responsible for the person's care because they are in a position of trust based on special knowledge

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that is not available to the layperson, including the average philosophically trained bioethicist.

This assumes what most bioethicists have consistently denied (e.g., Laurence McCullough and, of course, others like Veatch) (McCullough 1983). There is an inequality of knowledge distinguishing the physician from the layperson that extends to the specifics of diagnosis, the relative efficacy of treatment protocols, and the potential of various treatment patterns. We vest our physicians with ethical imagination because they are uniquely situated in the management of illness. Emotionally invested in the physician-patient relationship, the Hippocratic doctor seeks to provide the best care possible for the person in his or her care. A physician who loses a patient often undergoes a period of grief at his or her "failure," even when that death was inevitable. A craftsman whose chair is ruined by a slip of the hand or the automobile assemblyperson who improperly welds a door piece that must be scrapped does not suffer similarly.

"Knowing all there is to know about one's profession," writes Veatch, "does not give one expertise on questions of morality" (Veatch, 2012, 96). This would be true if that knowledge were merely technical. But it is also personal and social. The ethics of Hippocratic caring is enjoined not only in the classroom but also in the daily experience of progressive responsibility for fragile others. This is morality hard won and to deny it is to deny the reality not only of medical practice but the experience of the patient in need who turns to the physician for help.

In situations of medical uncertainty, the physician may argue against a patient's wishes or, in some rare cases, refuse them. Veatch sees this as a failure of the "paternalistic" Hippocratic ethic—they should do what they are told, or asked—and three times uses the nonpracticing pathologist, Jack Kevorkian, as a positive example of a physician who correctly acceded to patient demands. By his own admission, Kevorkian was responsible for well over one hundred deaths before his eventual conviction for manslaughter. None of those so terminated was Kevorkian's patient (Koch, 1998). Nor were any in the end stage of their illness, evidenced by the fact all traveled hundreds or thousands of kilometers to meet with him. Many were in the early stages of a disease and, with care, might have lived well for some years had they not died in his attendance. Some were, in fact, not physically sick at all. On autopsy no disease was identified. These were cases involving the misdiagnosis of psychiatric problems manifesting through physical symptoms. It is to avoid precisely this kind of unnecessary physician-assisted or initiated death that the Hippocratic *Oath*'s injunctions were first formulated.

Kevorkian's eventual conviction rested not on his violation of the Hippocratic *Oath* but on his violation of state laws prohibiting manslaughter. Unless one argues as an anarchist, or with a radically libertarian argument—which Veatch does not—one cannot logically insist on the primacy of state priorities, regulations, and, rules while simultaneously advancing

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Kevorkian as a model of the ethically neutral physician. One may argue state priorities should change to accommodate physician-assisted or physician-directed termination (Koch, 2013), but unless that happens a Kevorkian violates the state perspective that in theory Veatch believes should dominate. And the sorry record of the terminations Kevorkian helped perform stands as a stark reminder why the Hippocratic injunction against termination was first enjoined.

It is neither inappropriate nor paternalistic to refuse a patient's request for termination or for other treatments that a physician might believe dangerous, improper, or unsuitable. "Because he asked for it" is neither in ethics nor law a rational defense against inappropriate behavior by physicians or by anyone else older than, perhaps, five years of age. It does not justify beatings, injuries, or killings. In medicine what one actually seeks at the moment may be a request based on despair, depression, and fear. The Hippocratic physician engaged with the patient for his or her benefit understands this and, seeking the best treatment, seeks to explain that decision on the basis of personal experience and the best medicine that he or she could provide. It is precisely that reflexive posture, one that marries ethics and experience with technical expertise, that bioethical cadres seek to deny and then diminish or obliterate in favor of. . .something else.

VI. THE ETHICIST

Veatch specifically and bioethics generally advance an agenda that at first seems populist and modern. And yet Veatch at least is singularly unwilling to accept those norms when they contradict his prejudices. For example, he disparages as a "lingering Hippocratic notion" the Universal Declaration of Human Rights' insistence that "the interests and welfare of the human being shall prevail over the sole interest of society or science" (Veatch, 2012, 186). Nor, in the same passage, is he particularly happy with the article that promotes "equitable access to health care of appropriate quality" or another that insists research "must be carried out in accordance with relevant professional obligations and standards" (Veatch, 2012, 186). And yet, these are general ethical rules Declaration signatories have agreed to—the states whose sovereignty he advances—including the reference to "professional obligations and standards."

More generally, Veatch denies that there are professional obligations or standards—except for extremely technical guidelines—because he believes that ethical and moral legitimacy reside solely in the realm of religious leaders or philosophical adepts trained in moral philosophy (Veatch, 2012, 100–1). Nurses, physicians, and indeed all practitioners are for him mere technicians who lack the wherewithal to make ethical or moral judgments. Only the philosophically trained can make such judgments. But if physicians are

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incapable, why think average citizens more adept at ethical or moral problem solving? Were one concerned about paternalism in medicine, no greater paternalistic argument could be advanced than the exclusion of all from the domain of ethical and moral decision making other than the philosopher-bioethicist or the priest.

Parenthetically, it is worth noting that with this stance Veatch denies even the possibility of a "common morality" generally agreed to by a congress of untrained citizens. As a referent in bioethical reasoning, Beauchamp and Childress introduced the "common morality" as a replacement for the hard and fast universal principles they earlier had promoted in *Principles of Biomedical Ethics* (Beauchamp and Childress, 2001). The premise is that there are ethical and moral ideals (or principles) that are so consistent across a population (including doctors and nurses) and indeed all populations that they can be taken as universal. At present—as Veatch's own data makes clear—*The Oath*'s ethical injunctions currently employed in international covenants, medical schools, and as a basis for legal thinking come as close to a "common morality" as any can name. To deny that in favor of the trained philosopher's perspective (even were it not wholly contested) would be to introduce a paternalism so encompassing as to be rejected out of hand.

There is little that can be said to contradict an article of faith, especially one that defines a profession and a livelihood. It is pertinent, perhaps, to note that the record of morally trained philosophers active in medical ethics has been at best abysmal. Despite more than forty years of research and writing, they have found no universal canonical values that all ethicists can promote. They have provided no generally acceptable answer to ethical questions ranging from abortion and euthanasia to genetic testing and health care as a possible right. As a "demi-discipline" (Jonsen, 1997), bioethics has no central ethical or moral framework to which all bioethicists hold allegiance. Its writings remain a largely disparate set of opinions leavened by occasional philosophical snippets whose applications are in the main unclear (Baker and McCullough, 2007; Beauchamp, 2007). If philosophers cum bioethicists are the only ones to be trusted in these matters, we are all in serious trouble.

And even were there some unanimity, why think the moral philosopher cum ethicist more capable in areas of his or her ignorance—the care of persons who are frail and sick—than physicians might be in the realm of ethics and morality? The only way out of this conundrum is to employ Plato's fiction of the philosopher-king who, in *The Republic*, is solely capable of moral judgment that he then dictates to all. If we agree with Veatch, we can simply substitute bioethicists for royalty and assume in each bioethical fife an ethic devised by the local, regent moral philosopher will reign. It is worth noting, however, that in Plato's later work, *The Laws*, he reversed this position and diminished the sovereignty of the philosopher-king (Levin, 2012). Indeed, some have suggested *The Republic* was a satire whose views were exaggerated purposely,

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setting the stage for the more egalitarian social views presented in *The Laws* (Cady, 1983).

VII. CONCLUSION

There is nothing bizarre, cultish, or even particularly dated about the ethical imperatives of the Hippocratic *Oath*. Its insistence on patient care and health as a physician's primary duty presents an ethical imperative with ongoing ethical, legal, and social force. Neither *The Oath*, which is recited at hundreds of medical schools in a variety of languages, nor the medicine that Hippocrates described was secret. Indeed, it was their broad dissemination over centuries that permitted their near-universal adoption.

The Oath is given to physicians because they are the ones to whom society cedes primary responsibility for patient care. They have special knowledge about diagnosis and treatments not available to the average person and thus are given the responsibility to use that knowledge to promote the best interests of the patient in care. And, during working lives in which dilemmas of care are repeatedly faced, they are reasonably expected to have some special knowledge, drawn from constant experience, about the means of their resolution. The physician's judgment is not absolute but bounded, and since the Greeks the physician has sought to persuade but has rarely been permitted to insist on this or that treatment. Exceptions, typically disastrous, occurred in times when the state's priorities rather than the patients were seen as principal. Other exceptions occur today when a patient cannot choose for him or herself or when his or her life is at risk.

In Greece, serving the patient *was* serving society. And there is a similar sense of social purpose in *The Oath*'s invocation today. Where social goals seemed in conflict with *The Oath*'s imperatives it has stood, historically, as a bulwark (sometimes fragile and inadequate) against short-term priorities injurious to a patient's well-being. To insist on *The Oath* is not to disparage research. It is, however, to recognize that research needs are secondary to those of the person *in* need and that future benefits are secondary to the immediate necessities of individual care. To argue otherwise is to tip toward the totalitarian and to endanger us all.

The Great Proletarian Cultural Revolution lasted approximately ten years. Its anarchistic and then totalitarian vision proved inimical to social realities and the needs of either the state or its citizens. Bioethics has persisted in its cultural revolution for more than forty years, its cadres have now grown prestigiously settled in academia and government. In the first revolution, incalculable harm was the result. In this revolution, that harm has yet to be assessed, but its likelihood and potential are made evident in the substitution of political and "social" goals for personal care.

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