5-1-2018

The "New" Medical Morality: Hippocrates or Bioethics

Jeffrey H. Dobken
New York Medical College

The "New" Medical Morality: Hippocrates or Bioethics?

Jeffrey Hall Dobken, M.D., M.P.H.

David Rothman, the author of *"Strangers at the Bedside,"*[1] writes that the most "distinguishing characteristic of medical ethics [is] the extent to which it was monopolized by practicing physicians, not by formal [trained] philosophers…." He asserted that serious social, behavioral, and cultural issues had to be confronted. These issues served as the basis for the development of bioethics and for attacking traditional Hippocratic medical ethics.

Medical ethics discussions of the 21st century have become partitioned as political, social, religious, cultural, academic, economic, governmental, and business issues, while attention to the actual medical ethical content of any given patient-specific circumstance may be proscribed or very narrowly defined.

The notion of American "healthcare reform" has empowered a community of non-medically as well as medically trained philosophical theorists, also called "bioethicists," as the stewards of progressive medical ethics and thus the guardians of medical care. This is a complex, interwoven story and not simply, as an ethics argument might imply, a simple formulaic method establishing "right" from "wrong."

The "Failure" of Traditional Medical Ethics

Jerome Kassirer, former editor of the *New England Journal of Medicine*, articulated in 1998 that the reorganization of healthcare (referring to managed-care organizations and the Clinton Administration's proposed healthcare reform policies) had profoundly influenced physician roles, responsibilities and loyalties.[2] Kassirer suggested then that American physicians were unable to balance the kind of care delivered against the cost of care, creating an inequity between fee-for-service patients, covered patients, and non-covered patients, and that only outside (central) authority could craft a solution. Kassirer concluded that "until we physicians demanded a national health system (single payer), there could be no equity" and that our medical delivery system was, in fact, unethical.[3] This style of rhetoric attracted a following of academics and other supporters, some trained medical professionals and some not, to advance bioethics and its role in furthering "health care reform."

Kassirer's derogation of American medicine has been tested in the crucible created by the passage of centralized healthcare financing/insurance reimbursement reform, the Patient Protection and Affordable Care Act (PPACA or ACA). Along the way, bioethicists have volunteered their expertise and have, in large measure, enabled the transition from Hippocratic ethics to post-modern bioethics.

I now witness and experience the results as both a physician and a patient with a terminal disease. My case raises questions such as, "Is this really the best professionals can do?" and, by extension, "Has replacement of traditional Hippocratic ethics actually improved patient care?"

Since the enactment of PPACA and the subsequent remodeling, re-assigning, and displacement of the physician's role, the probability that a stranger will be at the bedside during the moments of critical decision-making or terminal crisis predicts that classic Hippocratic values will likely not apply. Instead, the decision process will pass through current (sometimes mandated) bioethics guidelines.[4] In this context, the neo-discipline of bioethics must be examined for moral effectiveness as well as clinical outcome. Perhaps the more acute question should be: Whose needs are being served, or whose interests being protected—those of the patient, the "system," or the bioethics community? What is the actual moral, ethical goal?

Ethical Conflicts and Dilemmas

Framing ethical questions has passed from the physician to the bioethicist, medically trained or not, and falls into two broad categories: what decision is "needed," and who should make the decision. Consider the hopelessly complicated and acrimonious debate surrounding the management and care of persons with life-limiting diagnoses and prognoses. The modification of language from "physician-assisted suicide" (PAS) to the "more acceptable" euphemism "physician-assisted death" (PAD) characterizes how the bioethics community controls the lexicon and gains ownership of an issue,[5] while marginalizing the physician.

In analyzing the results of their approach, bioethicists do not consider the outcome for the patient. Rather, they ask, "How effective is this bioethical approach?"

Societal concern about ethics relates to how to live an exemplary life by doing what is right. The exemplary life is one worthy of imitation, a role model for societal behavior. Today, we face the conundrum: What and who actually define what is "right" or "good"? These concepts become fluid in the current progressive sociocultural context.

Issues such as theistic beliefs, sexual identity, marital definition and fidelity, debate about rights, social "injustices" (or, broadly, "justice"), racial harmony, definition of honor and truth-telling, and fidelity to a code, have all morphed

into circumstantially defined concepts. Moreover, our dominant post-modern values definitions often seem to be conflicting or evolving (such as "gender identification," sexual orientation, diversity issues, white privilege, black privilege, personal responsibility, illegitimacy, motherhood vs. womanhood, etc.). This moral quicksand predicts confusion in general conduct and fosters intergenerational sociocultural conflict,[6] which then leads to the loss of a medical moral compass.

The Premises of Bioethics

The four core principles of bioethics are patient autonomy, provider beneficence (doing "good"), provider non-maleficence (doing no harm), and justice (treating equal cases equally). Tom Beauchamp, Ph.D., and James Childress, Ph.D., developed these four principles as derivative replacement values in their critique of what they considered to be an outdated and outmoded Hippocratic Oath, which in their view had been lost or diluted over time.[7]

Bioethicists consider themselves politically diverse guardians of social justice, and ultimately stewards of correct thinking and ethical experience. As such selfless, incorruptible individuals, they consider themselves well positioned to lecture those of us less educated in moral matters.[1]

The Evolution of Bioethics

In the mid-1960s Beauchamp and Childress provided debate rules with their core principles that established a checklist to solve moral ethical dilemma, with a focus on social and cultural issues.[8] These principles have evolved to control how bedside medical ethics are to be applied in the progressive, post-modern, post-Hippocratic era.

Bioethics defines itself as the field of study of the moral dimensions of the life sciences, derived from multiple ethical modalities in an interdisciplinary setting[9] and carried out by scholars who migrated to the field from diverse academic disciplines. The majority of the original academic philosophical scholars were not medical professionals, but moral philosophers, theologians, clergy, attorneys, hospital administrators, nurses, therapists, and others. Their academic degrees were in law, business, economics, health policy and management, public health, social science, political science, or allied health sciences such as pharmacology or nursing.

A short list of the ancient and contemporary philosophical approaches used to fabricate the ethical foundations of bioethics was synopsized by Diego Gracia.[10] The list demonstrates just how arcane and inaccessible the field is for those not intimately literate in pedantic philosophy: "phenomenology, hermeneutics, existentialism, care ethics, gender ethics, virtue ethics, communitarianism, discourse ethics and deliberate ethics have all been used to examine and explore medical ethics."[10] Expert bioethicists distinguish themselves from general members of society using language patterns or shibboleths.

An ex-president of the American Society of Bioethics and Humanities (ASBH), Mark Kuczewski, Ph.D., advanced that bioethicists serve as surrogates for the general public when issues of "ethical uncertainty" arise.[8] From the website of the ASBH:

> The Society is an educational organization whose purpose is to promote the exchange of ideas and foster multi-disciplinary, inter-disciplinary, and inter-professional scholarship, research, teaching, policy development, professional development, and collegiality among people engaged in all of the endeavors related to clinical and academic bioethics and the health-related humanities.[11]

The extension of this notion of an exchange of ideas, a "social ethical discussion," has evolved to co-opt medical database facts. Use assessments in the bioethics paradigm balance "cost versus value"[12] calculations by the Centers for Medicare and Medicaid Services (CMS) and the insurance payers. Acquisition of the medical database (lab tests, radiological assessment, biopsy, etc.) and treatment regimens (pharmacological to surgical to rehabilitation, etc.) have likewise been subject to bioethics scrutiny and judgment.[13]

The means to address ethical uncertainty, as defined by the bioethics community, is conceptualized as analytical thinking that is open to multiple interpretations and is based on a set of standards. These standards are set forth in the core competencies that ASBH members are expected to master and teach at the university or medical school level. There is also a specific code of conduct to which bioethicists are expected to adhere.[14]

The expectation of uniformity and conformity to this code contradicts any pretense of political diversity. There is demonstrable unanimity of techniques and purpose. In Kuczewski's words, bioethicists have "become a professional and academic community that engages in practices that include shared narratives, values, and virtues"[15] and thus will perform in a predictable and stereotypical manner. Establishing "bioethics considerations and guidelines" narrows the range of legitimate choices and limits physicians' autonomous choices.[8]

The stated aim of preserving and protecting individual autonomy in medical decision-making for patients and their families has not only become limited in such a climate, but has been effectively negated, even though it is still presented as a core principle.[7] Is this a subterfuge, or the inevitable unintended consequence of centrally planned and controlled health care decisions under the cloak of "moral authority and ethics"?

ASBH members are well-regarded, influential, and academically situated. They are employed by institutional review boards (IRBs), contribute to and edit medical and bioethical journals, testify in court, act as legislative

consultants, and are often media and internet celebrities. They demonstrate that, as H.L. Mencken said, "What men value in the world is "not rights, but privileges."[16]

The "demi-discipline" creation of Albert Jonsen, which is now independently powerful and politically progressive, has successfully displaced the traditional Hippocratic moral mile markers employed by the medical profession in virtually all the interactions that once defined the patient-physician relationship. This evolution was presumably needed to correct the traditional Hippocratic paternalism, portrayed as the adversary of autonomy. "Heroically," in its own estimation, bioethics oversaw the reformation of antiquated, inadequate Hippocratic ethics in the evolving and messy technological environment of the late 20th century.

Turning these progressive moral philosophers into practical "professional" medical ethicists who adjudicate complex medical practice standards, has in large part advanced the machinery needed to promote the "reform of American healthcare."

The Basic Premise

A "foundation myth" is a central hypothesis that defines and unifies a group or clique. Aristotle referred to a basic shared premise that distinguished truth-telling rhetoric from persuasive dialectic (sales pitch) in his classic *Art of Rhetoric*.[17] Enduring persuasion and subsequent behavior were achieved by leading the target of oratory (the audience to be persuaded) to a mutually acceptable novel central premise. In effect, once a group understood, appreciated, and accepted a novel concept, then comportment based on it could be expected. For example, accepting belief in a god or deity would predictably be accompanied by certain behavior, even though proof of the deity was anecdotal, ephemeral, or empirical. The belief represents the foundation myth.

The basic premise, the foundation myth of bioethics, can be found in the opening pages of Beauchamp and Childress's *Principles of Bioethics*, considered the bioethics bible:

> In the 1960s and 1970s a traditional ethics of medicine was shown to be insufficient in the face of an unprecedented series of advances in medical science and technology unfolding in an era of socioeconomic scarcity. Bioethics arose as a replacement capable of confronting these new realities. Grounded in a Western philosophical tradition (especially the writings of Immanuel Kant), bioethics would better serve in the evaluation (and employ) of these technologies. Further, bioethics was necessitated as a champion of individual freedom and patient choice in the face of illiberal and paternalistic practices common under older ethics of medicine (Hippocratic Ethic).
>
> With the rise of bioethics, a new class of medical professional came into being. This was the bioethicist, an expert in valuation uniquely qualified to apply philosophical systems of thought to ethical questions arising in areas of medical care, delivery, and research.[7]

As in our Aristotelean example, the myth's importance lies not in its inherent provability but rather in its acceptance. The Oath of Hippocrates does not fail to address ethical issues on the grounds that Beauchamp and Childress assert. Bioethics seeks to replace Hippocratic ethics because the focus in the Hippocratic paradigm is on the patient and the patient's illness, not on the "cost" of an illness to society. The Hippocratic notion is inimical to a progressive liberal process that assigns individual patient care as secondary to a set of social and economic priorities.

The principal emphasis of bioethics, according to Jonsen, was a gatekeeper duty that focused on community resources and distribution of sparse resources in an economic view based on a social justice ideology.[18] Bioethics rejects traditional medical ethics because traditional priorities were patient-oriented rather than socially derived. This shift from ancestral mores to prioritized social justice goals uses the notion of individual autonomy as its primary persuasive sales pitch. But in reality, bioethics espouses community values, social justice, and communal good as the desired and necessary priorities.

These goals appeal to the healthy well, and thus are readily saleable to society, including the "new class of medical professionals."[8] Daniel Callahan, the non-physician founder of the Hastings Center, wrote that bioethics triumphed because it was conducive to liberal sensitivities advanced within the progressively liberal climate of the American political marketplace.[19] That the transition from a patient-centered ethic to a liberal progressive population-centered ethic opened professional opportunities and positions of power and influence for the "trained bioethicist" (in government, hospital administrations, and, especially, academics) was well described in *Thieves of Virtue*, a brilliant and insightful critique by Tom Koch, a bioethicist.[8]

As Koch states, "[Bioethicists] promote as real and universal a moral perception whose end is moral action."[8] Allocation and administration of "scarce resources" for the benefit of the community trumps the Hippocratic focus on the individual ill and sick in favor of the many well. This may seem to be an appealing moral argument, but does it improve patient care?

Bioethicists further argue that Hippocratic ethics encourages physician greed and self-interest rather than altruism, and thus reinforce the need to replace Hippocratic mores. The quasi-autobiographical portrayal by bioethics elder statesman Albert R. Jonsen from his work *The New Medicine & the Old Ethics*[18] offers interesting insight into the grounds upon which the neo-discipline (Jonsen's terminology) was founded and justified. Jonsen is Professor and Chairman of the Department of Medical History and Ethics, School of Medicine, University of Washington, Seattle, Wash. He holds degrees in philosophy and religion and has no formal medical training. He writes that his work is "a

personal reflection reaching for insight into the encounter between the ethical tradition of Western medicine and the technological health care of today's world." He writes:

> As an ethicist, I am professionally concerned with ethical problems and the issues of the moral life. These can be found wherever human beings are found…. In medical care such topics abound: life-support systems, abortion, artificial hearts, genetic engineering, neonatal intensive care, and research with human subjects, euthanasia. And these are only a partial index of the moral problems in medicine. In my daily activities I deal, in theory and practice, with these issues. But there is something else, something much more fundamental and interesting, that draws me to the ethics of medicine and to doctor-watching….
>
> [T]he moral life of that world cannot be delineated in clear bright lines. It is rather a chiaroscuro in which shadowy figures from history, myth and tradition are often more powerfully present than the pallid propositions of philosophical ethics…. In medicine's moral history and present, [an ethical polarity] forms at the point where altruism and self-interest meet…. It is my thesis that medicine—as an institution, as a practice, as a profession—is dominated by the paradox [conflict between altruism and self-interest] in its starkest terms. (Said simply, greed and power have displaced altruism in the medical profession.)[18]

Jonsen sees the modern medical professional as mired in financial gain (self-interest) while being bereft of a sense of altruism. This deficiency has supposedly evolved from Hippocratic bedside ethics. Jonsen's perspective is that self-interest (power and money) has unraveled the moral fabric of the medical profession. It is this view and perspective that further buttresses the argument against the justifications of Hippocratic ethical traditions, and underscores the need for modernization/revision:

> There is a kind of moral archeology: digging beneath current moral beliefs, values, and practices, one discovers that these are built on ancient foundations not visible to the casual observer. The moral archeology of medicine exposes two traditions at the very deepest levels, one coming from ancient Greek medicine, the other from medieval Christian medicine. Scholarly studies of the Greek medical literature turn up precious little altruism in the ethics of the Hippocratic physician. Hippocratic medicine was a skill, its practitioners were craftsmen, and their objective was a good living. The etiquette that went by the name of ethics consisted of counsels of self-interest: "Act in this or that way with your patients if you want to build a reputation and a clientele."[18]

"The profession of medicine offers great rewards, not only of income but also of prestige, reputation and gratitude," observes Jonsen. This is the inheritance of the Greek tradition, he suggests, and contrasts it with the observation that modern medicine fails to provide help "desperately sought by persons often hard pressed to purchase it."

Jonsen is not isolated in his opinions of physician greed and his derogation of physician morality. Many well-reputed and influential academicians and professionals share his perspectives. These include: Ezekiel Emmanuel, physician and bioethicist, one of the architects and promoters of the PPACA, and a prominent member of the American Medical Association's Council on Ethical and Judicial Affairs (CEJA); George Annas, attorney, bioethicist, and master of public health; David Rothman, historian, bioethicist, professor of history at Columbia University, and director of the Center for the Study of Society and Medicine at Columbia College of Physicians and Surgeons; the late Uwe Reinhardt, economist and bioethicist of Princeton University; and many other academic authorities and voices.

According to Annas, "American society sees physicians more and more not as professionals governed by a strong ethical code, but as merchants who sell their goods and services to customers. This model has meant that consumer demand is the most important determinative of provider conduct."[20] The economist's model as described by Reinhardt states that "physicians will always behave so as to maximize the net hourly income that they can extract from the practice of medicine."[21] According to Rothman, bioethics "approaches the exercise of medical authority from the patient's point of view" but fails to address physician loyalties or the social purposes of medicine.[1] Most of the authority figures inside the bioethics community express similar opinions about physician "motives and ethics."

According to the bioethicists' view, the defects in American medicine and physicians flow from the Oath of Hippocrates: its antiquity, paternalism, ignorance of social justice, and its fostering of a greedy, self-interested monopolistic medical profession.

What Is Hippocratic Medicine?

Hippocratic medicine is an historical construct achieved by picking out themes and theories in a framework that was unknown during its own time but synthesized in retrospect by historians. The so-called Hippocratic Corpus was not a sole authorship, but rather the product of many authors over more than two centuries.[22] It is actually a library, or rather, the remains of a library.

Although the dozens of books included in the collection were originally attributed to Hippocrates himself, scholars now know that they were more likely composed between the sixth and fourth centuries B.C. During this time, a special kind of prose for medical writings developed in Greece. Although Cos, the island home of Hippocrates, is located off the coast of modern Turkey within what was a Doric-speaking region, the medical writers of Cos (believed to have written the Hippocratic treatises) appropriated the

more refined Ionic dialect of philosophy. Later, during the Renaissance, scientists like Andreas Vesalius would similarly shun using the vernacular, instead penning their medical treatises in Latin.

One of the earliest specimens of the Corpus is *On Ancient Medicine*, a tract written by an anonymous physician from the fifth century B.C. We can infer this author was both familiar with contemporary theory, and devoted to traditional lore and technique. This is one of two polemical works in the Hippocratic corpus; the other is *On the Sacred Disease*, which includes an early observation of epilepsy. Both works attack the concept of divine origin of disease and the intrusion of hypothetical philosophers into medicine.

Hippocratic medicine is holistic in a surprisingly modern sense, even though this holism was rooted in Greek cultural values. The ancient Greeks disliked dissection of human bodies. They performed no autopsies to determine cause of death, and Greek physicians taught no deep anatomy to apprentices. There were no medical schools in any modern sense. Students learned from masters, and what they knew was surface anatomy coupled with a shrewd sense of careful observation of their patients for signs suggesting the likely course of a suspected disease process, something which today would be qualified as careful, complete patient medical history documentation with assessment of disease pathophysiology and prognosis analysis. The Greek physician fulfilled his mission by predicting an outcome (whether the patient was likely to recover or not), but not the design of a complex treatment strategy. There were no hospitals; the bedside was literally the patient's own. In our world, "bedside" refers to an institution, such as a hospital or other care facility.

Ancient medical systems of the Near and Middle East (Egypt, Syria, Mesopotamia, Babylonia, and Greece) combined theology and healing. The priest and physician roles frequently blended and enjoyed a unique role in ancient society. Disease was widely believed to be the result of divine displeasure, transgressions of various kinds, or magical forces. Diagnoses might involve prayer, sacrifice of animals, examination of animal entrails, or determining otherwise how the patient had transgressed. This mix of magic and religious medicine was part of the Greek landscape during the time of Hippocrates. The physician-healer-priest was a servant or slave or merchant. Medicine was not a separate profession.[22]

Ancient Greek medicine and its holism make it the prototype of what we now designate as modern primary care. The Hippocratic doctor needed to know his patient thoroughly: his social, economic, and familial circumstances; his diet; his travel history; his habits; and his disease tendencies.

This describes what once was called a complete anamnesis, or medical history, performed by the physician as an essential tool for diagnosis, but also creating a bond with the patient that fostered trust and intimacy. Now, this task is generally assigned to "physician extenders" (medical receptionists, information technology personnel, nurses, physician assistants, etc.), who use waiting room questionnaires destined for electronic entry into a blended electronic medical record for demographic analysis and interpretation and, of course, coding.

The basis of Hippocratic medical morality is trust. Koch describes the manner in which trust in physicians as caring professionals creates a social good and contract.[8]

The Oath of Hippocrates was a part of a whole social contract appropriate to antique Greek culture. Even though the Oath named a pantheon of gods and goddesses (Apollo, Aesculapius, Hygeia, Panacea, and "all the gods and goddesses"), its moral authority was not based on religion. Rather, it was an ethical covenant that operated at three levels. First, it bound the physician to his master and teacher, his teachings and standards of practice in a compact of mutual assistance, cooperation, loyalty, and learning. Second, the Oath defined the goal of practitioners as the care of the sick without regard to income or standing. Third, the Oath tied the community of physicians to the good of society at large.

The reward for honorable practice came not from the gods nor from financial rewards but from the communities and citizens served by the physician: so long as the physician adhered to the tenets of the Oath he would "enjoy life and the practice of the art, respected by all men." It enabled trust.

Under this Hippocratic ethic, medical practitioners pledged themselves to a code of conduct and practice that was equally social and medical. Ancient Greeks identified so strongly with their city-states that they did not distinguish between their own interests and the interests of the community in which they lived.[8] The Oath was thus the obligation of a specific set of community members who saw their interests, those of their patients, and the interests of the community at large as inextricably intertwined. Those who swore to the Oath were acknowledged as moral agents whose income was derived from the sale of their services to other citizens. As caregivers of the individuals they served, they also served the broader good of the state.

The Oath encompasses two themes: First was the creation of a collegial value system essential to advance the assembly, sharing, and distribution of medical knowledge among and for a community of colleagues. The second theme defined ethical responsibilities characterizing the fee-for-service practitioner and the sale of services. Care, not income, was to be the primary virtue of the Hippocratic practitioner: "Into whatever homes I go, I will enter them for the benefit of the sick, avoiding any voluntary act of impropriety or corruption." The famous "first, do no harm" reinforced this caring goal. Refraining from acts that in any manner might violate the sanctity of life and/or the privacy or trust of the patient was the principal moral value underpinning the Oath.

The Oath also prohibited specific social improprieties, such as having sex with patients or members of a patient's

family or household, whether rich or poor, slave or free, or violating privacy in general (in private conversations, for example). These prohibitions cemented the bond of trust with patients and their families, and ensured that the Hippocratic physician, even though a stranger, would be seen as a trustworthy moral agent, who was not acting selfishly or to exploit, but only to deliver care appropriately and without ulterior motive.

The history of the Hippocratic Corpus suggests that the success of the Hippocratic physician and his comportment created an envelope of trust that held sway well into our mid-20th century. Its antiquity—Hippocrates preceded Plato, Aristotle, and other classic figures of ancient Athenian culture—makes the survival of the Hippocratic Corpus all the more remarkable. People save what works, and what they value.

Conclusion

Medicine and idealism have always been comfortable companions. There have always been and likely always will be practitioners whose medical practice was and is self-serving and exploitative. In the main, however, the Hippocratic ideal sets a moral standard that survived the centuries. It envisions the care of the sick as individual occurrences in the context of the needs of society. But collective society is not the patient. Bioethics represents a radical shift in focus away from the individual to the collective. The implications for patient care deserve sharp scrutiny, not blind acceptance of bioethical premises based on prestige and proclaimed lofty intentions.

Jeffrey Hall Dobken, M.D., M.P.H., holds a dual appointment as adjunct assistant professor, Departments of Epidemiology & Community Health and Environmental Sciences, School of Health Sciences and Practice, New York Medical College. He was a practicing allergist in N.J. and holds a certificate in bioethics from the Center for the Study of Society & Medicine, College of Physicians and Surgeons, Columbia University. Contact: jhdobken@verizon.net.

REFERENCES

1. Rothman DJ. *Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making.* New York, N.Y.: Basic Books; 1992.
2. Kassirer JP. Managing care—should we adopt a new ethic? *NEJM* 1998:339:397-398.
3. Dobken J. The deconstruction of medical ethics. *J Am Phys Surg* 2010;15:80-84.
4. Dobken J. On POLST: new lyrics, old melody. *MedPage Today,* Oct 1, 2010. Available at: https://www.medpagetoday.com/columns/and-now-a-word/22528. Accessed May 26, 2018.
5. Health and Medicine Division. National Academies of Sciences, Engineering, and Medicine. Physician-assisted Death: Scanning the Landscape and Potential Approaches. Workshop; Feb 12-13, 2018.
6. Coreil J. *Social and Behavioral Foundation of Public Health*. 2nd ed. Thousand Oaks, Calif. SAGE; 2009.
7. Beauchamp T, Childress J. *Principles of Biomedical Ethics.* 7th ed. New York, N.Y.: Oxford University Press; 2013.
8. Koch T. *Thieves of Virtue: When Bioethics Stole Medicine.* Cambridge, Mass.: MIT Press; 2014.
9. Jonsen AR. *The Birth of Bioethics.* New York, N.Y.: Oxford University Press; 1998.
10. Gracia D. Philosophy: ancient and contemporary approaches. In: Sugarman J, Sulmasy DP. *Methods in Medical Ethics*. 2nd ed. Washington, D.C.: Georgetown University Press; 2010: 55-72.
11. American Society for Bioethics + Humanity. About. Available at: http://asbh.org/about/american-society-bioethics-humanities. Accessed Oct 14, 2016.
12. Jones C, MacHarris M. Transitioning from the Physician Quality Reporting System (PQRS) to the Merit-based Incentive Payment System (MIPS). *MLN Connects*. Centers for Medicare & Medicaid Services; Jan 22, 2017. Available at: https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2017-01-24-PQRS-MIPS-Presentation.pdf. Accessed May 26, 2018.
13. Baumin S, Kristeller R, Dobken J. Clinicians at the crossroads: must fidelity to individual patients be sacrificed for the public good? 233rd Annual Meeting, Medical Society of New Jersey, Atlantic City, N.J.; May 4, 1999.
14. ASBH. Guidelines and Standards. Available at: http://asbh.org/publications/guidelines-standards. Accessed May 26, 2018.
15. Kuczewski, M. Taking it personally: reflections on living bioethics and medical humanities. *ASBH Reader*, Summer/Fall, 2010:3-9.
16. Winokur, J. *The Portable Curmudgeon*. New York, N.Y.: New American Library; 1987.
17. Aristotle. *The Art of Rhetoric*. Lawson-Tancred H, trans. London, England: Penguin Books; 1991.
18. Jonsen AR. *The New Medicine and the Old Ethics.* Cambridge, Mass.: Harvard University Press; 1990.
19. Callahan D. Why America accepted bioethics. *Hastings Center Report*. 1992;23(6):58.
20. Annas GJ. Law, medicine, and ethics: 20 years after Quinlan. Quinlan: A Twenty Year Retrospective. Conference Syllabus, Princeton, N.J.: UMDNJ-Center for Continuing Education; 1996.
21. Reinhardt UE. The economist's model of physician behavior. *JAMA* 1999;281:462-465.
22. Bynum W. *The History of Medicine: A Very Short Introduction*. Oxford University Press; 2008.