

Hippocratic Oath -- Classical Version

I swear by Apollo Physician and Asclepius and Hygieia and Panacea and all the gods and goddesses, making them my witnesses, that I will fulfil according to my ability and judgment this oath and this covenant:

To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art - if they desire to learn it - without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but no one else.

I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.

I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art.

I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work.

Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves.

What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about.

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

Translation from the Greek by Ludwig Edelstein. From The Hippocratic Oath: Text, Translation, and Interpretation, by Ludwig Edelstein. Baltimore: Johns Hopkins Press, 1943.

The Virtues and Obligations of Professionals

EDMUND D. PELLEGRINO

The Virtuous Physician and the Ethics of Medicine

Consider from what noble seed you spring: You were created not to live like beasts, but for pursuit of virtue and of knowledge.

Dante, *Inferno* 26, 118–120

THE VIRTUOUS PERSON, THE VIRTUOUS PHYSICIAN

Virtue implies a character trait, an internal disposition, habitually to seek moral perfection, to live one's life in accord with the moral law, and to attain a balance between noble intention and just action. Perhaps C. S. Lewis has captured the idea best by likening the virtuous man to the good tennis player: "What you mean by a good player is the man whose eye and muscles and nerves have been so trained by making innumerable good shots that they can now be relied upon. . . . They have a certain tone or quality which is there even when he is not playing. . . . In the same way a man who perseveres in doing just actions gets in the end a certain quality of character. Now it is that quality rather than the particular actions that we mean when we talk of virtue" [1].

On almost any view, the virtuous person is someone we can trust to act habitually in a 'good' way — courageously, honestly, justly, wisely, and temperately. He is committed to *being* a good person and to the pursuit of perfection in his private, professional and communal life. He is someone who will act well even when there is no one to applaud, simply because to act otherwise is a violation of what it is to be a good person. No civilized society could endure without a significant num-

ber of citizens committed to this concept of virtue. Without such persons no system of general ethics could succeed, and no system of professional ethics could transcend the dangers of self-interest. That is why, even while rights, duties, obligations may be emphasized, the concept of virtue has 'hovered' so persistently over every system of ethics.

Is the virtuous physician simply the virtuous person practicing medicine? Are there virtues peculiar to medicine as a practice? Are certain of the individual virtues more applicable to medicine than elsewhere in human activities? Is virtue more important in some branches of medicine than others? How do professional skills differ from virtue? These are pertinent questions propaedeutic to the later questions of the place of virtue in professional medical ethics.

I believe these questions are best answered by drawing on the Aristotelian-Thomist notion of virtues and its relationship to the ends and purposes of human life. The virtuous physician on this view is defined in terms of the ends of medicine. To be sure, the physician, before he is anything else, must be a virtuous person. To be a virtuous physician he must also be the kind of person we can confidently expect will be disposed to the right and good intrinsic to the practice he professes. What are those dispositions?

To answer this question requires some exposition of what we mean by the good in medicine, or more specifically the good of the patient — for that is the end the patient and the physician ostensibly seek. Any theory of virtue must be linked with a theory of the good because virtue is a disposition habitually to do the good. Must we therefore know the nature of the good the virtuous man is disposed to do? As with the definition of virtue we are caught here in another perennial

Reprinted from Earl E. Shelp (ed.), *Virtue and Medicine: Exploration in the Character of Medicine* (Philosophy and Medicine Series, No. 17), pp. 243–255. © 1985 by D. Reidel Publishing Company. Reprinted by permission of Kluwer Academic Publishers.

philosophical question—what is the nature of the Good? Is the good whatever we make it to be or does it have validity independent of our desires or interest? Is the good one, or many? Is it reducible to riches, honors, pleasures, glory, happiness, or something else?

I make no pretense to a discussion of a general theory of the good. But any attempt to define the virtuous physician or a virtue-based ethic for medicine must offer some definition of the good of the patient. The patient's good is the end of medicine, that which shapes the particular virtues required for its attainment. That end is central to any notion of the virtues peculiar to medicine as a practice.

I have argued elsewhere that the architectonic principle of medicine is the good of the patient as expressed in a particular right and good healing action [2]. This is the immediate good end of the clinical encounter. Health, healing, caring, coping are all good ends dependent upon the more immediate end of a right and good decision. On this view, the virtuous physician is one so habitually disposed to act in the patient's good, to place that good in ordinary instances above his own, that he can reliably be expected to do so.

But we must face the fact that the 'patient's good' is itself a compound notion. Elsewhere I have examined four components of the patient's good: (1) clinical or biomedical good; (2) the good as perceived by the patient; (3) the good of the patient as a human person; and (4) the Good, or ultimate good. Each of these components of patient good must be served. They must also be placed in some hierarchical order when they conflict within the same person, or between persons involved in clinical decisions [3].

Some would consider patient good, so far as the physician is concerned, as limited to what applied medical knowledge can achieve in *this* patient. On this view the virtues specific to medicine would be objectivity, scientific probity, and conscientiousness with regard to professional skill. One could perform the technical tasks of medicine well, be faithful to the skills of good technical medicine per se, but without being a virtuous person. Would one then be a virtuous physician? One would have to answer affirmatively if technical skill were all there is to medicine.

Some of the more expansionist models of medicine—like . . . that of the World Health Organization (total well-being)—would require compassion, empathy, advocacy, benevolence, and beneficence, i.e., an expanded sense of the affective responses to patient need [4]. Some might argue that what is required,

therefore, is not virtue, but simply greater skill in the social and behavioral sciences applied to particular patients. On this view the physician's habitual dispositions might be incidental to his skills in communication or his empathy. He could achieve the ends of medicine without necessarily being a virtuous person in the generic sense.

It is important at this juncture to distinguish the virtues from technical or professional skills, as MacIntyre and, more clearly, Von Wright do. The latter defines a skill as 'technical goodness'—excellence in some particular activity—while virtues are not tied to any one activity but are necessary for "the good of man" ([5], pp. 139–140). The virtues are not "characterized in terms of their results" ([6], p. 141). On this view, the technical skills of medicine are not virtues and could be practiced by a non-virtuous person. Aristotle held *techne* (technical skills) to be one of the five intellectual virtues but not one of the moral virtues.

The virtues enable the physician to act with regard to things that are good for man, when man is in the specific existential state of illness. They are dispositions always to seek the good intent inherent in healing. Within medicine, the virtues do become in MacIntyre's sense acquired human qualities ". . . the possession and exercise of which tends to enable us to achieve those goods which are internal to practices and the lack of which effectively prevents us from achieving any such goods" ([7], p. 178).

We can come closer to the relationship of virtue to clinical actions if we look to the more immediate ends of medical encounters, to those moments of clinical truth when specific decisions and actions are chosen and carried out. The good the patient seeks is to be healed—to be restored to his prior, or to a better, state of function, to be made 'whole' again. If this is not possible, the patient expects to be helped, to be assisted in coping with the pain, disability or dying that illness may entail. The immediate end of medicine is not simply a technically proficient performance but the use of that performance to attain a good end—the good of the patient—his medical or biomedical good to the extent possible but also his good as he the patient perceives it, his good as a human person who can make his own life plan, and his good as a person with a spiritual destiny if this is his belief [8]. It is the sensitive balancing of these senses of the patient's good which the virtuous physician pursues to perfection.

To achieve the end of medicine thus conceived, to practice medicine virtuously, requires certain dispositions: conscientious attention to technical knowledge and skill to be sure, but also compassion—a capacity to feel something of the patient's experience of illness and his perceptions of what is worthwhile; beneficence and benevolence—doing and wishing to do good for the patient; honesty, fidelity to promises, perhaps at times courage as well—the whole list of virtues spelled out by Aristotle: “. . . justice, courage, temperance, magnificence, magnanimity, liberality, placability, prudence, wisdom” (*Rhetoric*, 1, c, 1366b, 1–3). Not every one of these virtues is required in every decision. What we expect of the virtuous physician is that he will exhibit them when they are required and that he will be so habitually disposed to do so that we can depend upon it. He will place the good of the patient above his own and seek that good unless its pursuit imposes an injustice upon him, or his family, or requires a violation of his own conscience.

While the virtues are necessary to attain the good internal to medicine as a practice, they exist independently of medicine. They are necessary for the practice of a good life, no matter in what activities that life may express itself. Certain of the virtues may become duties in the Stoic sense, duties because of the nature of medicine as a practice. Medicine calls forth benevolence, beneficence, truth telling, honesty, fidelity, and justice more than physical courage, for example. Yet even physical courage may be necessary when caring for the wounded on battlefields, in plagues, earthquakes, or other disasters. On a more ordinary scale courage is necessary in treating contagious diseases, violent patients, or battlefield casualties. Doing the right and good thing in medicine calls for a more regular, intensive, and selective practice of the virtues than many other callings.

A person who is a virtuous person can cultivate the technical skills of medicine for reasons other than the good of the patient—his own pride, profit, prestige, power. Such a physician can make technically right decisions and perform skillfully. He could not be depended upon, however, to act against his own self-interest for the good of his patient.

In the virtuous physician, explicit fulfillment of rights and duties is an outward expression of an inner disposition to do the right and the good. He is virtuous not because he has conformed to the letter of the law, or his moral duties, but because that is what a good

person does. He starts always with his commitment to be a certain kind of person, and he approaches clinical quandaries, conflicts of values, and his patient's interests as a good person should.

Some branches of medicine would seem to demand a stricter and broader adherence to virtue than others. Generalists, for example, who deal with the more sensitive facets and nuances of a patient's life and humanity must exercise the virtues more diligently than technique-oriented specialists. The narrower the specialty the more easily the patient's good can be safeguarded by rules, regulations, rights and duties; the broader the specialty the more significant are the physician's character traits. No branch of medicine, however, can be practiced without some dedication to some of the virtues [9].

Unfortunately, physicians can compartmentalize their lives. Some practice medicine virtuously, yet are guilty of vice in their private lives. Examples are common of physicians who appear sincerely to seek the good of their patients and neglect obligations to family or friends. Some boast of being 'married' to medicine and use this excuse to justify all sorts of failures in their own human relationships. We could not call such a person virtuous. Nor could we be secure in, or trust, his disposition to act in a right and good way even in medicine. After all, one of the essential virtues is balancing conflicting obligations judiciously.

As Socrates pointed out to Meno, one cannot really be virtuous in part:

Why did not I ask you to tell me the nature of virtue as a whole? And you are very far from telling me this; but declare every action to be virtue which is done with a part of virtue; as though you had told me and I must already know the whole of virtue, and this too when frittered away into little pieces. And therefore my dear Meno, I fear that I must begin again, and repeat the same question: what is virtue? For otherwise, I can only say that every action done with a part of virtue is virtue; what else is the meaning of saying that every action done with justice is virtue? Ought I not to ask the question over again; for can any one who does not know virtue know a part of virtue? (*Meno*, 79)

VIRTUES, RIGHTS AND DUTIES IN MEDICAL ETHICS

Frankena has neatly summarized the distinctions between virtue-based and rights- and duty-based ethics as follows:

In an ED (ethics of duty) then, the basic concept is that a certain kind of external act (or doing) ought to be done in cer-

tain circumstances; and that of a certain disposition being a virtue is a dependent one. In an EV (ethics of virtue) the basic concept is that of a disposition or way of being—something one has, or if not, does—as a virtue, as morally good; and that of an action's being virtuous or good or even right, is a dependent one [10].

There are some logical difficulties with a virtue-based ethic. For one thing, there must be some consensus on a definition of virtue. For another there is a circularity in the assertion that virtue is what the good man habitually does, and that at the same time one becomes virtuous by doing good. Virtue and good are defined in terms of each other and the definitions of both may vary among sincere people in actual practice when there is no consensus. A virtue-based ethic is difficult to defend as the sole basis for normative judgments.

But there is a deficiency in rights- and duty-ethics as well. They too must be linked to a theory of the good. In contemporary ethics, theories of good are rarely explicitly linked to theories of the right and good. Von Wright, commendably, is one of the few contemporary authorities who explicitly connects his theory of good with his theory of virtue. . . .

In most professional ethical codes, virtue- and duty-based ethics are intermingled. The Hippocratic Oath, for example, imposes certain duties like protection of confidentiality, avoiding abortion, not harming the patient. But the Hippocratic physician also pledges: “. . . in purity and holiness I will guard my life and my art.” This is an exhortation to be a good person and a virtuous physician, in order to serve patients in an ethically responsible way.

Likewise, in one of the most humanistic statements in medical literature, the first century A.D. writer, Scribonius Largus, made *humanitas* (compassion) an essential virtue. It is thus really a role-specific duty. In doing so he was applying the Stoic doctrine of virtue to medicine [11].

The latest version (1980) of the AMA 'Principles of Medical Ethics' similarly intermingles duties, rights, and exhortations to virtue. It speaks of 'standards of behavior', 'essentials of honorable behavior', dealing 'honestly' with patients and colleagues and exposing colleagues 'deficient in character'. The *Declaration of Geneva*, which must meet the challenge of the widest array of value systems, nonetheless calls for practice 'with conscience and dignity' in keeping with 'the honor and noble traditions of the profession'. Though their first allegiance must be to the Communist ethos, even the Soviet physician is urged to preserve 'the high

title of physician', 'to keep and develop the beneficial traditions of medicine' and to 'dedicate' all his 'knowledge and strength to the care of the sick'.

Those who are cynical of any protestation of virtue on the part of physicians will interpret these excerpts as the last remnants of a dying tradition of altruistic benevolence. But at the very least, they attest to the recognition that the good of the patient cannot be fully protected by rights and duties alone. Some degree of supererogation is built into the nature of the relationship of those who are ill and those who profess to help them.

This too may be why many graduating classes, still idealistic about their calling, choose the Prayer of Maimonides (not by Maimonides at all) over the more deontological Oath of Hippocrates. In that 'prayer' the physician asks: “. . . may neither avarice nor miserliness, nor thirst for glory or for a great reputation engage my mind; for the enemies of truth and philanthropy may easily deceive me and make me forgetful of my lofty aim of doing good to thy children.” This is an unequivocal call to virtue and it is hard to imagine even the most cynical graduate failing to comprehend its message.

All professional medical codes, then, are built of a three-tiered system of obligations related to the special roles of physicians in society. In the ascending order of ethical sensitivity they are: observance of the laws of the land, then observance of rights and fulfillment of duties, and finally the practice of virtue.

A legally based ethic concentrates on the minimum requirements—the duties imposed by human laws which protect against the grosser aberrations of personal rights. Licensure, the laws of torts and contracts, prohibitions against discrimination, good Samaritan laws, definitions of death, and the protection of human subjects of experimentation are elements of a legalistic ethic.

At the next level is the ethics of rights and duties which spells out obligations beyond what law defines. Here, benevolence and beneficence take on more than their legal meaning. The ideal of service, of responsiveness to the special needs of those who are ill, some degree of compassion, kindness, promise-keeping, truth-telling, and non-maleficence and specific obligations like confidentiality and autonomy, are included. How these principles are applied, and conflicts among them resolved in the patient's best interests, are subjects of

widely varying interpretation. How sensitively these issues are confronted depends more on the physician's character than his capability at ethical discourse or moral casuistry.

Virtue-based ethics goes beyond these first two levels. We expect the virtuous person to do the right and the good even at the expense of personal sacrifice and legitimate self-interest. Virtue ethics expands the notions of benevolence, beneficence, conscientiousness, compassion, and fidelity well beyond what strict duty might require. It makes some degree of supererogation mandatory because it calls for standards of ethical performance that exceed those prevalent in the rest of society [12].

At each of these three levels there are certain dangers from over-zealous or misguided observance. Legalistic ethical systems tend toward a justification for minimalistic ethics, a narrow definition of benevolence or beneficence, and a contract-minded physician-patient relationship. Duty- and rights-based ethics may be distorted by too strict adherence to the letter of ethical principles without the modulations and nuances the spirit of those principles implies. Virtue-based ethics, being the least specific, can more easily lapse into self-righteous paternalism or an unwelcome over-involvement in the personal life of the patient. Misapplication of any moral system even with good intent converts benevolence into maleficence. The virtuous person might be expected to be more sensitive to these aberrations than someone whose ethics is more deontologically or legally flavored.

The more we yearn for ethical sensitivity the less we lean on rights, duties, rules, and principles, and the more we lean on the character traits of the moral agent. Paradoxically, without rules, rights, and duties specifically spelled out, we cannot predict what form a particular person's expression of virtue will take. In a pluralistic society, we need laws, rules, and principles to assure a dependable minimum level of moral conduct. But that minimal level is insufficient in the complex and often unpredictable circumstances of decision-making, where technical and value desiderata intersect so inextricably.

The virtuous physician does not act from unreasoned, uncritical intuitions about what feels good. His dispositions are ordered in accord with that 'right reason' which both Aristotle and Aquinas considered essential to virtue. Medicine is itself ultimately an exercise of practical wisdom—a right way of acting in difficult and uncertain circumstances for a specific end,

i.e., the good of a particular person who is ill. It is when the choice of a right and good action becomes more difficult, when the temptations to self-interest are most insistent, when unexpected nuances of good and evil arise and no one is looking, that the differences between an ethics based in virtue and an ethics based in law and/or duty can most clearly be distinguished.

Virtue-based professional ethics distinguishes itself, therefore, less in the avoidance of overtly immoral practices than in avoidance of those at the margin of moral responsibility. Physicians are confronted, in today's morally relaxed climate, with an increasing number of new practices that pit altruism against self-interest. Most are not illegal, or, strictly speaking, immoral in a rights- or duty-based ethic. But they are not consistent with the higher levels of moral sensitivity that a virtue-ethics demands. These practices usually involve opportunities for profit from the illness of others, narrowing the concept of service for personal convenience, taking a proprietary attitude with respect to medical knowledge, and placing loyalty to the profession above loyalty to patients.

Under the first heading, we might include such things as investment in and ownership of for-profit hospitals, hospital chains, nursing homes, dialysis units, tie-in arrangements with radiological or laboratory services, escalation of fees for repetitive, high-volume procedures, and lax indications for their use, especially when third party payers 'allow' such charges.

The second heading might include the ever decreasing availability and accessibility of physicians, the diffusion of individual patient responsibility in group practice so that the patient never knows whom he will see or who is on call, the itinerant emergency room physician who works two days and skips three with little commitment to hospital or community, and the growing over-indulgence of physicians in vacations, recreation, and 'self-development.'

The third category might include such things as 'selling one's services' for whatever the market will bear, providing what the market demands and not necessarily what the community needs, patenting new procedures or keeping them secret from potential competitor-colleagues, looking at the investment of time, effort, and capital in a medical education as justification for 'making it back', or forgetting that medical knowledge is drawn from the cumulative experience of a multitude of patients, clinicians, and investigators.

Under the last category might be included referrals on the basis of friendship and reciprocity rather than

skill, resisting consultations and second opinions as affronts to one's competence, placing the interest of the referring physician above those of the patients, [and] looking the other way in the face of incompetence or even dishonesty in one's professional colleagues.

These and many other practices are defended today by sincere physicians and even encouraged in this era of competition, legalism, and self-indulgence. Some can be rationalized even in a deontological ethic. But it would be impossible to envision the physician committed to the virtues assenting to these practices. A virtue-based ethic simply does not fluctuate with what the dominant social mores will tolerate. It must interpret benevolence, beneficence, and responsibility in a way that reduces self-interest and enhances altruism. It is the only convincing answer the profession can give to the growing perception clearly manifest in the legal commentaries in the FTC [Federal Trade Commission] ruling that medicine is nothing more than business and should be regulated as such.

A virtue-based ethic is inherently elitist, in the best sense, because its adherents demand more of themselves than the prevailing morality. It calls forth that extra measure of dedication that has made the best physicians in every era exemplars of what the human spirit can achieve. No matter to what depths a society may fall, virtuous persons will always be the beacons that light the way back to moral sensitivity; virtuous physicians are the beacons that show the way back to moral credibility for the whole profession.

Albert Jonsen, rightly I believe, diagnoses the central paradox in medicine as the tension between self-interest and altruism [13]. No amount of deft juggling of rights, duties, or principles will suffice to resolve that tension. We are all too good at rationalizing what we want to do so that personal gain can be converted from vice to virtue. Only a character formed by the virtues can feel the nausea of such intellectual hypocrisy.

To be sure, the twin themes of self-interest and altruism have been inextricably joined in the history of medicine. There have always been physicians who reject the virtues or, more often, claim them falsely. But, in addition, there have been physicians, more often than the critics of medicine would allow, who have been truly virtuous both in intent and act. They have been, and remain, the leaven of the profession and the hope of all who are ill. They form the sea-wall that will not be eroded even by the powerful forces of commercialization, bureaucratization, and mechanization inevitable in modern medicine.

We cannot, need not, and indeed must not, wait for a medical analogue of MacIntyre's 'new St. Benedict' to show us the way. There is no new concept of virtue waiting to be discovered that is peculiarly suited to the dilemmas of our own dark age. We must recapture the courage to speak of character, virtue, and perfection in living a good life. We must encourage those who are willing to dedicate themselves to a "higher standard of self effacement" [14].

We need the courage, too, to accept the obvious split in the profession between those who see and feel the altruistic imperatives in medicine, and those who do not. Those who at heart believe that the pursuit of private self-interest serves the public good are very different from those who believe in the restraint of self-interest. We forget that physicians since the beginnings of the profession have subscribed to different values and virtues. We need only recall that the Hippocratic Oath was the Oath of physicians of the Pythagorean school at a time when most Greek physicians followed essentially a craft ethic [15]. A perusal of the Hippocratic Corpus itself, which intersperses ethics and etiquette, will show how differently its treatises deal with fees, the care of incurable patients, and the business aspects of the craft.

The illusion that all physicians share a common devotion to a high-flown set of ethical principles has done damage to medicine by raising expectations some members of the profession could not, or will not, fulfill. Today, we must be more forthright about the differences in value commitment among physicians. Professional codes must be more explicit about the relationships between duties, rights, and virtues. Such explicitness encourages a more honest relationship between physicians and patients and removes the hypocrisy of verbal assent to a general code, to which an individual physician may not really subscribe. Explicitness enables patients to choose among physicians on the basis of their ethical commitments as well as their reputations for technical expertise.

Conceptual clarity will not assure virtuous behavior. Indeed, virtues are usually distorted if they are the subject of too conscious a design. But conceptual clarity will distinguish between motives and provide criteria for judging the moral commitment one can expect from the profession and from its individual members. It can also inspire those whose virtuous inclinations need re-enforcement in the current climate of commercialization of the healing relationship.

To this end the current resurgence of interest in virtue-based ethics is altogether salubrious. Linked to a theory of patient good and a theory of rights and duties, it could provide the needed groundwork for a reconstruction of professional medical ethics as that work matures. Perhaps even more progress can be made if we take Shakespeare's advice in *Hamlet*: "Assume the virtue if you have it not. . . . For use almost can change the stamp of nature."

NOTES

1. Lewis, C.: 1952, *Mere Christianity*, Macmillan Co., New York.
2. Pellegrino, E.: 1983, 'The Healing Relationship: The Architectonics of Clinical Medicine', in E. Shelp (ed.), *The Clinical Encounter*, D. Reidel, Dordrecht, Holland, pp. 153-172.
3. Pellegrino, E.: 1983, 'Moral Choice, The Good of the Patient and the Patient's Good', in J. Moskop and L. Kopelman (eds.), *Moral Choice and Medical Crisis*, D. Reidel, Dordrecht, Holland.
4. Engel, G.: 1980, 'The Clinical Application of the Biopsychosocial Model', *American Journal of Psychiatry* 137: 2, 535-544.
5. Von Wright, G.: 1965, *The Varieties of Goodness*, The Humanities Press, New York.
6. Ibid.
7. MacIntyre, A.: 1981, *After Virtue*, University of Notre Dame Press, Notre Dame, Indiana.
8. Pellegrino, E.: 1979, 'The Anatomy of Clinical Judgments: Some Notes on Right Reason and Right Action', in H. T. Engelhardt, Jr., et al. (eds.), *Clinical Judgment: A Critical Appraisal*, D. Reidel, Dordrecht, Holland, pp. 169-194. Pellegrino, E.: 1979, 'Toward a Reconstruction of Medical Morality: The Primacy of the Act of Profession and the Fact of Illness', *Journal of Medicine and Philosophy* 4: 1, 32-56.
9. May, W.: Personal communication, 'Virtues in a Professional Setting', unpublished.
10. Frankena, W.: 1982, 'Beneficence in an Ethics of Virtue', in E. Shelp (ed.), *Beneficence and Health Care*, D. Reidel, Dordrecht, Holland, pp. 63-81.
11. Cicero: 1967, *Moral Obligations*, J. Higginbotham (trans.), University of California Press, Berkeley and Los Angeles. Pellegrino, E.: 1983, 'Scribonius Largus and the Origins of Medical Humanism', address to the American Osler Society.
12. Reeder, J.: 1982, 'Beneficence, Supererogation, and Role Duty', in E. Shelp (ed.), *Beneficence and Health Care*, D. Reidel, Dordrecht, Holland, pp. 83-108.
13. Jonsen, A.: 1983, 'Watching the Doctor', *New England Journal of Medicine* 308: 25, 1531-1535.
14. Cushing, H.: 1929, *Consecratio Medici, and Other Papers*, Little, Brown and Co., Boston.
15. Edelstein, L.: 1967, 'The Professional Ethics of the Greek Physician', in O. Temkin (ed.), *Ancient Medicine: Selected Papers of Ludwig Edelstein*, Johns Hopkins University Press, Baltimore.