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CHAPTER 6

Codes, Virtue, and Professionalism

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Until very recently, in both Eastern and Western medicine, codes of ethical conduct provided the only source of judgment of good and bad, right and wrong, professional conduct. They were, therefore, the only method of ethical argumentation. However, from the beginning of the contemporary era of medical ethics, ethical codes have been challenged by a wide variety of alternate modes of argumentation, as the other chapters in this book attest. Nonetheless, in most of the world, among professionals and laypersons, codes continue to set standards for ethical conduct, to define new ethical issues, and to support one position or another in ethical discourse.

The purpose of this chapter is to examine the use of codes in medical ethical discourse, to define their sources of moral authority, and to relate them to virtues and professionalism. Properly employed, professional codes still have an important place in medical practice, provided their limitations are taken into account and their moral precepts are grounded more securely in a moral philosophy of the professions. The delimitation of such a philosophy has been a long-term project of the author of this chapter and his colleague, David C. Thomasma (Pellegrino 2008).

Description of Codes, Virtue, and Professionalism

The discussion of codes, virtue, and professionalism proceeds as follows: an overview of the historical presence and ubiquity of ethical codes in medicine; the use of codes in argumentation; challenges to the moral authority of codes; proposed sources of their moral authority, including an argument relating codes to virtue and professionalism based on a moral philosophy of medicine; and the abuse of codes.

THE PERSISTENCE AND UBIQUITY OF CODES

It is important at the outset to distinguish codes from oaths, with which they are frequently confused. Sulmasy has made this distinction quite explicit (Sulmasy 1999). He understands an oath to be a formal, solemn, publicly proclaimed commitment to conduct oneself in certain morally specified ways. Codes, on the other hand, are simply enumerations, codifications, or collations of a set of moral precepts. One may

or may not swear fidelity to a code. When one does swear solemnly to abide by a specific codification of moral precepts, then code and oath coincide but do not lose their separate identities. This chapter refers to the codification, and not necessarily the oath to abide by that codification.

No attempt is made here to summarize the history, variable content, or provenance of the wide variety of ethical codes now extant in the medical and other health professions (Etziony 1973; Konold 1978; Veatch 1978; Gorlin 1995; Spicer 1995). Rather, the focus here will be on the Hippocratic ethic, that is, the Hippocratic Oath and the other so-called deontological books: *Precepts*, *Decorum*, *Law*, *The Physician*, and *Aphorisms* (Hippocrates 1972, vol. 1; Hippocrates 1981, vol. 2; Hippocrates 1979, vol. 4). The multitudinous medical oaths and codes of the modern era reflect, in significant degree, the prescriptions and proscriptions of these books of the Hippocratic ethic. For this reason the Hippocratic Oath will be used as a paradigm for this inquiry into the use of codes in ethical argumentation.

Today, the popularity of codes is not limited to medicine. One of the most active areas is in business and corporate ethics. In recent decades U.S. businesses have sought to combat public distrust by institutionalizing ethics (Sims 1994). For example, in 1990, of the Fortune 500 companies that responded to a survey, 94 percent had ethics codes, 32 percent had ethics committees, and 15 percent employed full-time ethicists (Petry 1993). Many of the issues addressed in this chapter with regard to medical codes, their use in argumentation, and their moral authority can be found in the expanding literature relative to business codes.

Despite the criticisms and doubts about the moral authority of professional codes, they continue to proliferate. The second edition of the *Encyclopedia of Bioethics* takes 243 pages simply to reproduce the texts of codes related to the health professions (Spicer 1995). Veatch lists forty-one health professions with codes (1978). Gorlin presents fifty-one codes in business, health, and law (1995). The Hippocratic Oath is simply an orally verbalized code. Recitation of the Hippocratic Oath, or some variation of it, is regaining popularity in American medical schools after a lapse some years ago (Orr et al. 1997). Clearly there is a latent attraction to codes as a mark of serious professionalism, even though the degree to which they are observed or felt to be binding is in considerable doubt.

In medicine professional codes go back at least to the ancient Code of Hammurabi (1792–1750 BCE), which, itself, was probably derived from earlier Sumerian sources dating to 3000 BCE (*Encyclopedia Britannica* 1979; Hamarneh 1993). Since then, every era and all the major cultures have produced codifications of right and wrong professional behavior (Muthu 1930; Bar-Sela and Hoft 1962; Etziony 1973; Levey 1977; Temkin 1991; Baker, Porter, and Porter 1993; Baker 1994). In the West the dominant code of oldest provenance is the Hippocratic Oath and elements drawn from the deontologic books of the Hippocratic corpus. The oath and its ethic, revised to conform to theological presuppositions, were given added moral authority during late antiquity and the Middle Ages by the major monotheistic religions (Temkin 1991; Amundsen 1996).

All these codes and their variations describe in some detail what was expected in the way of moral conduct, as well as personal decorum of those who professed to

be physicians. Taken together, their prescriptions and proscriptions constitute the Hippocratic ethos and ethic or, more simply, the Hippocratic tradition. They survive, with suitable modification, in the multiplicity of codifications adapted for virtually all the health professions.

To be sure, the Hippocratic ethic has undergone changes in language, interpretation, and emphasis over the centuries (Baker 1993). It was never fully embraced by all physicians in any era. It was frequently violated by individual physicians, or modified or reshaped to suit contemporary mores—just as it is being reshaped today. Some historians have taken those uncertainties of provenance and interpretation as reasons to deny or doubt that the Hippocratic code was ever a universal, unchanging set of moral principles (Baker 1993; Nutton 1995).

Those ambiguities are significant, but they must not obscure the fact that despite changes and variations in interpretation, codes have persisted for 2,500 years in Western and Eastern medicine. There is still substantial agreement across historical eras and cultures on many of the core precepts of these codes (Pellegrino 1999). Until the past several decades, the Hippocratic ethos and its variants have carried significant moral authority for many physicians. However, in the last few decades the widespread deconstruction of the Hippocratic Oath and ethics has made it mandatory to develop a moral philosophy for medicine on which the normative authority of the code can be based (Pellegrino and Thomasma 1981; Pellegrino 2001; Jotterand 2005).

CODES AS AN ARGUMENT FROM AUTHORITY

Strictly speaking the use of professional codes in moral discourse and argumentation does not fit precisely under the rubric of "methodology" as that term is used to define other modes of argumentation represented in this book. Codes are not modes of analysis, like the application of prima facie principles or the use of paradigm cases, as in casuistry. Neither are they elements of a robust moral philosophy external to medicine, such as Kantian deontology, Millian utilitarianism, Thomistic natural law, or Aristotelian virtue theory. Rather, the Hippocratic code and its historical congeners are assertions of moral precepts presented as self-evident and self-justifying prima facie obligations.

Nonetheless, codes are the reference point for a long-standing method when they are used in argumentation. Their method is the rhetorical method of the argument from authority. In classical logic as well as in scientific reasoning, arguments from authority have often been judged to be the weakest sort of argument. Yet arguments from authority are used universally—in court cases, in everyday discourse, in scholarly papers, and even in scientific investigations. Moreover, argument from authority has been recognized in classical rhetoric as a valid form of argumentation under certain specified conditions that define its valid use (St. Aubyn 1985; Perelman 1982; Weston 1992; Scriven 1976; Mackin 1969).

In classical logic the argument from authority was known as *argumentum ad verecundiam*; that is, an argument accepted out of deference for the prestige, stature, or presumed expertise of a person, institution, or office holder. This argument gained a bad reputation because of its frequent misuse and because it was used in the wrong

context (e.g., in matters where demonstrable truth was possible) or without proper qualification (e.g., when Nobel laureates in physics or chemistry expatiate on theological or moral matters or on clinical medicine). The strength and validity of any argument from authority vary directly with the strength of the proof of that authority's qualification to command respect.

Thus, in theology, for those who believe in God, argument from authority, as with the Ten Commandments, is the strongest possible argument. It is absolute, and given that premise, it overrides every other argument. Believers may differ in their interpretation of precisely what these divine commands require but not with their authority as binding obligations. For nonbelievers, on the other hand, the Decalogue is, at best, a social construction and subject to challenge and doubt just as the Hippocratic ethic is today.

A related mode of argument is the *argumentum ad populum*, which appeals to general opinion, to categories of people who hold a certain view, or to a cultural or ethnic tradition. This argument has understandable appeal in democratic societies. Like the argument from authority, great dissonance can result from differences in interpretation of what is popular opinion. *Argumentation ad populum* is classically understood to be a weaker argument than argument from authority—to be used sparingly and only when demonstrable proof, valid expertise, or other arguments are not available (Weston 1992).

The moral authority of a professional act cannot be based, therefore, on the fact that it is sanctioned by a majority of physicians, the law, or the general public. This would give moral status to social or public opinion, which per se is not a source of moral justification. In the recent past pathological communities and societies, for example, have completely subverted medical ethics to political or social ideologies. This is the danger in all forms of social constructions of morals. While more sophisticated than a simple argument by public opinion, social construction suffers the same limitations. Such arguments surface whenever the possibility of objective moral truth is abandoned. When this occurs the validity of the moral authority of a professional code can be established only by first establishing the moral validity of the community giving it its consensus.

To be valid and effective, any argument from authority must establish the qualifications of the authority, whether that authority is vested in a person, institution, or tradition (Dauber 1996). The authority must be free of conflicts of interest and use expertise in the right circumstances and the right field of inquiry. Genuine qualification and appropriate context are the two essentials of the valid use of authority in argument.

The use of codes in medical ethics argumentation clearly is dependent, therefore, upon the legitimacy of the moral authority of the code in question. Today the authenticity of the moral authority of any code is under significant attack. An essential step, therefore, in a consideration of codes as a method of argumentation is to examine the criticisms of the paradigm medical ethical code, the Hippocratic Oath, and then to establish its moral authority as clearly as possible. Only then can we proceed to delineate the proper and improper ways of employing codes to define or settle an ethical issue or question.

CHALLENGES TO THE MORAL AUTHORITY OF CODES

In recent years, as a result of intensive historical and social scrutiny, the moral authenticity and authority of the Hippocratic Oath and ethic are suspect. Some critics interpret it as a self-serving creed, created by a self-appointed guild to monopolize the healing arts (Berlant 1975). Others reject it as unilaterally proclaimed, rather then being a contract negotiated between individual patients, society, and physicians (Veatch 1991). Still others see physician– and nurse–patient relationships as matters of character: virtuous persons have no need for codes; those who need them are unlikely to respect them (Lebacqz 1985; Warren 1993). Rules may impede the exercise of virtue, displace accountability from persons to codes, and foster "cookbook" ethics (Sanders 1993).

Still further, some see codes as impediments to teaching ethics since they encourage the simplistic reading of codes as duties to be accepted on authority alone (Kluge 1992). In addition they are thought to stifle individual expression (Downey and Calman 1994). Others, however, argue that the use of codes may, in fact, require heightened ethical sophistication (Hussey 1996).

An increasingly widespread criticism is that the inherent anachronism of any unchanging code cannot carry moral authority in our times, which are characterized by changes in gender, power, and societal mores and the commercialization and bureaucratization of medicine. The admixture of ethics and etiquette in the Hippocratic ethic bespeaks an outdated elitism, insincerity of motive, and obsession with personal comportment (Foot 1972; Goodfield 1973; Newton 1978; Sugarman 1994).

The more pragmatic critics point out that codes have historically been ineffective in making physicians virtuous. This is clear from the many times ethical imperatives have had to be imposed on the profession—for example, the code of Hammurabi (1792–1750 BCE); in Babylonian times, the *Lex Aquilia*; in Roman times, the *Lex Cornelia*; the German "medical police" (Castiglioni 1941; Frank 1976; *Encyclopedia Britannica* 1979) in the nineteenth century; and the medical licensing authorities in the United States today. Moreover, some critics argue that codes cannot be effective without better support systems for whistleblowers, without which, as Tadd writes, self-regulation of the profession becomes a mockery (1994). Nutton (1995) has recently summarized many of the common criticisms of the Hippocratic Oath and casts doubt as well on the current resurgence of interest in the oath, attributing it to a desire for ceremony as a substitute for religious belief and exclusivity.

More recently Miles (2004) has offered a series of criticisms of the Hippocratic ethic from a sociohistorical perspective. He faults it for its insensitivity to matters of social justice in the distribution of health care resources, to the difficulties of defining right and wrong in a changing, morally pluralist society, and to the deprofessionalization of the doctor by the societal mechanisms within which he or she must function today.

In a comprehensive article Jotterand (2005) reviews these and other criticisms of the Hippocratic ethic. To remedy them, he makes a strong case for a moral philosophy of medicine to undergird its ethics. This is the same proposal that Thomasma

and I (1988, 1997; Pellegrino 2008) have made for many years. Indeed, we have suggested a moral philosophy derived from the nature of medicine as a special kind of human relationship that entails certain ethical obligations on the part of those who profess it. For us this is an ethic of medicine, an internal morality of medicine, based on the existential realities of being ill, needing healing and helping, and the act of profession of the physician as a promise to help and heal.

This is not the place to attempt to evaluate or respond to each of those criticisms. Obviously, anyone who intends to adhere to the precepts of the Hippocratic code or any professional codes must be aware that there is some measure of truth in many of them. One must decide whether a code is simply a social construct without any intrinsic claim to moral authority, whether it has a claim to authority that is only transient and subject to change in response to social preferences, or whether the moral authority of medical codes rests in their being stable reflections of moral obligations rooted in the nature of medicine itself.

SOURCES OF MORAL AUTHORITY

It becomes important, therefore, to examine the possible sources of moral authority of professional codes. These sources of moral authority may be derived externally—that is, from moral theories outside medicine—or internally, from the nature and ends of medicine itself.

External sources of moral authority

One possible means of justifying medico-moral codes is by applying general moral theories to the practice of medicine. The code that results is derived from each moral theory.

Social construction. A widely accepted source for the moral authority of codes (and the one inherent in most of the criticisms cited above) is some form of social construction. In this view the ends of medicine are grounded in societal consensus about the uses and goals that medicine should pursue. Here, codes are instruments designed to attain certain predefined social ends of medicine. The ethics of medicine derives from whatever values, guidelines, beliefs, or principles a society chooses to impose upon its practitioners at a particular time.

The requisite consensus can be derived in several ways. One way is by plebiscite or referendum, where a majority vote of the polity would be decisive. This is, in effect, to equate the major tenets of democratic political philosophy with moral discourse. Another way that the precepts of a code could be determined would be by their fitting into a coherence theory; that is, by the fit or misfit of the precepts within a context of other beliefs already socially accepted. Still another method of social construction is reflective equilibrium, whereby judgments about particular theories or precepts are tested systematically for congruence or incompatibility with particular judgments and vice versa. The socially preferred or accepted precepts are those that come closest to equilibrium between a theory and particular judgments.

Another form of social construction is the social contract—as construed by Hobbes, Locke, and Rousseau. In this view the relationship of a profession with

society is in the form of a mutually constructed contract. Society affords certain privileges to a profession in order to gain, in return, the special services that the profession can provide. Here the moral authority of a code resides in the bilateral obligations of the contracting parties. As a result the obligations incurred are social constructions whose authority depends on societal concurrence.

The moral authority of a socially constructed code is defined by particular social forces in particular historic settings. It is subject, therefore, to continuing processes of change. Today, such codes must accommodate the prevalent mores of moral pluralism and moral skepticism. In this setting, linkages between physicians and patients of different cultures or nations would be morally insecure. The notion of a moral tradition would be suspect.

Deontology. Another external source of moral authority would be Kantian deontology. L'tang (1992) argues that professional codes are codifications of Kantian perfect duties; that is, duties that are obligatory because they derive from the categorical imperative. According to this view, to generate valid duties, codes must be voluntary and must shape the will of the participants, irrespective of personal inclination. The difficulty here is that codes are intended to articulate specific precepts to guide professional action whereas the categorical imperative is the standard by which every potential precept ought to be evaluated. L'tang recognizes this limitation but justifies the Kantian approach by what it can contribute to policy formulation and decision procedures and by its insistence on the participation of rational, autonomous human beings (1992).

Utilitarianism. Starr justifies the moral authority of codes on grounds of their socially useful consequences, such as the stability of society and the establishment of a set of expectations to guide law and policies (1982). Professional codes also yield social benefits for all by encouraging physician compliance.

Utility as a source of moral authority encounters the usual problems of any utilitarian theory: defining what precisely is in the public interest, quantifying and calculating utility, and paying inadequate attention to intentionality. Moreover, the way utility itself is to be defined is problematic. As totalitarian regimes have repeatedly demonstrated, professional ethics are susceptible to subversion and compromise with nonmoral or immoral societal purposes (Pellegrino 1995).

Prima facie justification. W. D. Ross's notion of prima facie obligations has enjoyed wide popularity as a basis for biomedical ethics (1988; Beauchamp and Childress 1994). It appeals to many professionals as a justification of professional codes as well. According to this view some set of rules or precepts could gain universal approbation as reflections of a common morality. These rules become prima facie obligations to be respected ipso facto unless some overriding justification could be offered for violating them.

The problem with prima facie principles as the basis of moral authority is that they require agreement on a common morality. This is more and more difficult to attain in today's pluralistic, multicultural, morally divided societies. Also, there remains the problem of reconciling prima facie rules when they conflict with each other.

Postmodern ethics. Postmodernism is a multifaceted philosophical and cultural movement with many ramifications for codes of ethics. Postmodernists deny the validity of any foundational theory for moral authority and, thus, any stable codification of moral precepts. They would read a professional code of ethics as a text susceptible, like any other text, to deconstruction and individual interpretation.

The only possible basis for moral authentication would be praxis (Toulmin 1997). If a code worked—for example, in the sense of achieving some measurable difference in conduct—it would be authenticated. The problem, of course, is that what works may not be moral. In any case one would have to define both terms: "works" and "moral." This would press us to find some other justification for moral authority. Some suggest that the normative dimension can be reintroduced by the fact that everyone is a game-player and moral norms are the rules of the game (Nuyen 1998). This is a far cry from the ideal of a code. It reduces ultimately to another form of social construction.

Internal sources of moral authority

Two internal sources of moral authority rest in the practitioners of the profession in question and the activity peculiar to the profession they practice. One source consists in practitioners' discerning, through moral reflection, something special in their art that imposes moral obligations upon them. A second source is found in a more formal analysis of the peculiar nature of the practice, its ends, purposes, and phenomena, from which a set of duties is derived if the defined goals are to be achieved.

Moral reflections of practitioners. In its origins the Hippocratic Oath was developed as a statement of freely asserted moral precepts without argumentation. A group of physicians in ancient Greece saw their art intuitively as a moral enterprise that required a high degree of moral commitment. By their collective oath, they committed themselves publicly to beneficence, confidentiality, competence, and fidelity to promises, while abjuring maleficence, abortion, euthanasia, and sexual congress with patients. Their profession of this oath carried with it the penalty of reproach for its infraction. By their collective oath, they recognized that commitment and thus established themselves as a moral community distinct from the main body of practitioners of their day (Edelstein 1943; Carrick 1985).

The validity of those moral commitments should rest on their merit, not on the way in which they were derived or proclaimed. The voluntary taking of the oath is a freely made promise and, as such, is binding, like all promises, on those who make the promise in good faith. This was the case with those physicians, few or many, who took the Hippocratic Oath in centuries past and those who take it today, and it serves as one source of the Hippocratic Oath's moral authority. But the moral validity of the oath transcends communal or societal acceptance.

A teleological account of moral authority. I contend that what the Hippocratic physicians grasped intuitively as the moral basis for their oath was the moral imperative embedded in the nature of their art. They took the end of that art to be relief of pain and suffering, lessening what they called the violence of the disease—thus, healing.

Moreover, the first moral precept of the oath (its first codification in ethics) is the promise to use medical knowledge for the good of the patient and to refrain from harm—deemed to be that which distinguished medicine from other arts (Hippocrates 1981). Plato discerns this more explicitly, setting medicine apart from carpentry or navigation or money making by its end and function (*Cratylus; The Republic*). For both Plato and Aristotle medicine was the paradigm of an art, or *tekné*, practiced within a moral framework.

In its classical Platonic, Aristotelian, and Thomistic sense, the term "teleology" refers to the study of ends. This differs from the modern Benthamite or Millian ethical teleology with emphasis on consequences or outcomes. Classically, the *telos* of a thing is intrinsic to its nature, to what it is, what it is intended for, and what its purpose is. The essence of an act and its *telos* are connected in such a way that an act is a good act of its kind if it attains its proper end or purpose, its *telos*.

In this way the end or purpose is linked with the good. To know the end is to know the particular excellence that can enable one to attain it with perfection (Guthrie 1971). In moral terms this idea of the *telos* incorporates an "ought" dimension. Any trait or disposition that enables an agent to achieve the end is a virtue; that is, it confers a power (*virtus*) to attain that end with perfection.

Aristotle incorporated this notion of *telos* in his definition of final causes and his definition of a definition (*Metaphysics*; *Posterior Analytics*). It was further refined by Thomas Aquinas, who defined both the good and the end as being "that for the sake of which other things are done" (1960). Aquinas is quite specific about teleology as the basis for ethics "so the subject matter of moral philosophy is human action as ordered to an end or even man as he is acting voluntarily for the sake of an end" (1960).

This concept of teleology, classically defined, is not consistent with current consequentialist preferences for social constructions of the goals of medicine. Indeed, the use of goals as opposed to ends in a new treatment of this subject is indicative of the contemporary preference (Hanson and Callahan 1999). Goals are human societal constructs and can be changed at will. Ends, on the other hand, have an ontological status that is not susceptible to manipulation even for ostensibly good reasons. Those objections notwithstanding, it is important to compare and contrast a teleological account of the moral basis of codes with contemporary theories.

Let us now apply this notion of *telos* and its accompanying ethic of the good to medicine. Such an account provides the elements of an internal morality of medicine and, thus, a moral philosophy for medical practice. Medicine exists because humans become ill and want to heal, ameliorate, cure, or prevent this universal human frailty. These are the ends of medicine, those things that define it for what it is. These are, therefore, the good for which medicine strives and for which health professionals act.

Physicians, nurses, and other health professionals are the human agents through whom the essential ends of medicine are achieved. They effect these ends in clinical medicine through particular relationships with individual patients. The *telos*, or end, of the clinical relationship is the same as the generic *telos* of medicine as an art. This generic end is brought about clinically through a more proximate and specific end—namely, making and effecting a technically right and morally good healing

decision for, and with, a particular patient (Pellegrino and Thomasma 1988). A right decision is one that is scientifically correct; that is, it is congruent with the best scientific evidence. A good decision is one that is morally good; that is, it is in the best interests of the patient and protects or preserves the good of the patient. The good of the patient is, in turn, a composite notion of four elements: the medical good; the patient's perception of his or her good; the good of the patient as a human being; and the spiritual good of the patient (Pellegrino and Thomasma 1988).

The good of the patient thus defined is the immediate end of the clinical encounter attained through making right and good decisions, and these, in turn, serve the more distant good of the restoration of the patient's health, care, cure, or amelioration of illness or disability. Medicine is judged good or bad depending on whether it facilitates those ends. Those ends are intrinsic to medicine, and those who practice this art are under a moral constraint to bring them about. The ethics of medicine arises, therefore, in the nature of medicine, in the definition of its ends, and in the possession, by the medical agent, of those traits of character that enable and empower the closest approach possible to those ends.

The ancient codes of medicine and their contemporary counterparts are public commitments to strive to attain the ends of medicine. They are implicitly proclaimed in the codes that commit doctors to the patient's good through fulfillment of duties and necessary virtues. Thus, in the Hippocratic ethic, one finds the positive duties of beneficence and nonmaleficence; fidelity to trust; preservation of confidences; and not taking sexual advantage of patients, not practicing abortion or euthanasia, and not engaging in practices beyond one's competence. Professional codes of medicine are explicit declarations of commitment to those duties that are required if the ends of medicine are to be attained and a physician is to be a good physician.

A teleological validation of moral authority yields a professional code at variance with current moral theory. Such a code is essentialist, stable at least in its core precepts, and universally binding on all who profess to be healers. It would eliminate from the codes those elements that cannot be justified on grounds of the ends and nature of medicine or the other health professions. It would hold all members of a profession who ascribed to the code morally responsible for its observance.

If a minimal core of moral commitments can be fashioned that focuses on the obligations of health professionals as professionals, there is every probability that it would eventuate in a code common to all health professions. Such an effort is under way under auspices of the Tavistock Group, which is attempting to fashion a guide to ethical decision making for all health professionals (Smith, Hiatt, and Berwick 1999). What is proposed is a set of universal principles that might apply to health care systems throughout the world. Allowance would be made for additional ethical principles peculiar to each of the separate professions. Some differences suited to national, sociopolitical, and economic preferences are contemplated as well.

If such a universal code were to succeed, its moral authority would have to be derived from something more fundamental than the interests or assertions of any one of the health professions. The moral grounding in the primacy of the welfare of those to be served will be essential. Only in this way will the differences between health care systems and health professionals be reconciled. Only in this way can a legitimate and

morally defensible criterion be established to distinguish essential from nonessential or self-defeating differences in ethical guidelines.

In today's moral discourse, the objections to a teleological essentialist derivation of moral authority are many. First is the total negation of any theory of a stable foundation for moral philosophy. Second is the tendency to confuse classical teleology with theological cosmology; that is, the argument for a design built into nature in the form of unbreakable laws. Third is the antimetaphysical conviction of contemporary philosophy. Fourth is the postmodern resistance to the possibility of grasping moral truths by the use of reason. Finally, any teleological ethic based in objective reality is susceptible to the accusation of the naturalistic fallacy; namely deriving an "ought" conclusion from an "is" premise—an error in moral reasoning pointed out by David Hume and G. E. Moore.

This is not the place for a rebuttal of the arguments against the teleological foundation for the moral authority of codes. The purpose of the preceding section has been to illustrate ways moral authority can be established. Which one is chosen will condition the form of the dialogue. But without some degree of moral authority, there can be no dialogue or argumentation.

THE ABUSE OF CODES

As indicated at the beginning of this chapter, the methodology underlying the use of codes is the rhetorical methodology of the argument from authority. The use or abuse of codes is determined in terms of the criteria for a valid argument from authority. These criteria in moral argumentation reduce to: the authenticity and validity of the authority cited; the use of that authority in the proper context; and the absence of conflicts of interest.

Even if a robust interpretation of the moral authority of a code is accepted based on one of the justificatory arguments discussed above, that authority, like any authority, can be misused so that it becomes self-defeating and ineffective. Indeed, some of the current criticisms of codes speak more of their misuse than to a fundamental moral defect. There are many ways to misuse the authority of codes.

For example, the code may be cited to claim or defend some self-serving professional prerogative, such as restricting the exercise of a legitimate technical expertise by members of other health professions. Similarly, some physicians might claim that the code demands so much of them morally that they are thereby justified in assuming moral primacy in team decisions or disputes. Some doctors read the Hippocratic Oath, for example, as giving them automatic leadership of the health care team or the right to dictate what is right or wrong without challenge from their colleagues. Still others take the oath to be a unilateral license to paternalism that brooks no disagreement.

Some also misuse the code to argue against the need for teaching medical ethics or for further analysis and study of its history, meanings, and interpretation. It is said that everything can be deduced from the Hippocratic Oath or reduced to the simple phrase "Do no harm." This ignores the fact that beneficence, rather than nonmaleficence, is the first moral principle of the code and of the whole Hippocratic ethic.

It also ignores the fact that codes, however defensible their moral precepts may be, are subject to continuing analysis of their moral implications as each new clinical dilemma presents itself.

A few physicians may still quote the preamble of the Hippocratic Oath to justify their preferences for elitism, sexism, or the guild mentality. These elements of the oath may not even have been part of the original text. In any case they would not survive ethical scrutiny today. Neither were they ever ethically defensible on principled grounds.

An overemphasis on the etiquette of the so-called deontological books of the Hippocratic corpus that focuses on details of comportment, dress, manner, and style may encourage honoring professional loyalty over loyalty to the welfare of patients. This misinterpretation is especially dangerous in matters of malpractice, physicians' personal conduct, or protection of the impaired physician. To err in that way is to subvert patients' interests to those of physicians—a clear violation of the central commitment of the oath to patient welfare. It is worth bearing in mind that the intentional or unintentional misuse, abuse, or violation of a code does not vitiate the code itself.

The grossest documented abuse of the Hippocratic ethic was that of the physicians of the Third Reich. Those who were indicted for their roles in human experimentation and the Holocaust protested that they had obeyed the precepts of the oath (Pellegrino 2009; Pellegrino and Thomasma 2000). Indeed, a telling lesson of the Nuremberg trials was the fragility of the Hippocratic Oath and ethic, resting as they do on moral assertion without a moral philosophy to ground them more securely.

The fragility of the oath also has been evidenced by its more subtle deconstruction in the last several decades as its precepts have been subjected to individual interpretations. In this era of autonomy, individual preference, freedom of choice, and moral skepticism, many physicians feel free to pick and choose which precepts (if any) they will accept or reject. The variability of oaths at medical commencements attests to the growing insistence on a more secular-sounding, more inclusive oath. This variability is exacerbated by the gradual transformation of patient autonomy into patient sovereignty (Veatch 2008).

Without a moral philosophy to ground them, the Hippocratic Oath and ethic are fragile and are threatened with progressive fragmentation and, perhaps, complete dissolution.

Concluding Comments

A code binds physicians not only because they have voluntarily and publicly proclaimed allegiance to it but also because its moral precepts can be individually justified and defended by sound moral argumentation. Despite the emergence of a variety of other powerful methods of doing medical ethics, codes will continue to play a prominent role in the indefinite future. They are simple, direct codifications of moral conduct to which large numbers of today's professionals commit themselves. If codes are to satisfy the rhetorical canons for the proper use of arguments from authority, the moral authority of codes will have to be continually validated. This means that scholarly study of codes remains a requisite for sound discourse in medical ethics.

Inquiry into the provenance, content, sociohistorical settings, and social evolution of the meanings of codes will require the knowledge and skills of sociology, history, and politics. Inquiry into the philosophical origins and moral validity of codes and their critical evaluation against modern ethical theory and practice will require the skills of philosophers. Relating these facets of codes to each other will demand a level of interdisciplinary study difficult to attain. In all of this the error of presentism—that is, interpreting events of the past in terms of the present—must be avoided. Equally seductive is the misuse and abuse of texts simply to score a victory in argument.

In the end the major problem is not the fragility of the code but the character of the physician. Any moral code must be translated into a moral act by a human person, and that moral act will reflect the moral values and sensitivities of that agent. In this view virtues are character traits that predispose the physician habitually to act in such a way that the intended end (which is the fundamental point of the code) is the good of the patient. To achieve that end entails certain virtues both intellectual and moral.

Thomasma and I (1988, 1993) have identified those virtues as practical wisdom (prudence), justice, temperance and courage, as well as fidelity to trust, benevolence, some suppression of self-interest, intellectual and personal honesty, humility, and compassion. In our view these virtues are entailed by the nature of the physician–patient relationship, that is, by what the physician promises and the patient is entitled to receive.

The strongest assurance of the code's survival is the fact that it speaks to realities of human existence that do not change in their essence. As long as humans are mortal, they will become ill and will face predicaments that will give rise to a need for assistance from someone who professes and practices healing and helping. The nature of the predicament of one human seeking help from another who offers to help is what prompted a small group of Greek physicians to commit themselves to moral obligations they freely assumed. That reality is today more complex and filled with more hope for comfort or cure, but it is also as central to human welfare as it has always been.

Notes on Resources and Training

Those who plan research in professional codes, and especially the Hippocratic code, may do so from a wide variety of perspectives—including historical, sociological, and philosophical. Educational requirements will vary with the perspective chosen. Serious textual scholarship regarding ancient declarations requires knowledge of the languages in which they were written. What can be certain is that this is a well-tilled field of scholarship. This does not preclude further study but does require in-depth preparation if new insights are to be discovered.

The literature on professional ethics in general, and medical ethics in particular, is voluminous. The citations in the references for this chapter are a small sample, selected for their relevance to the limited question of the use and abuse of codes in bioethical argumentation. Each contains an extensive bibliography that can be used to extend the reader's studies further.

1. The article on codes in the *Encyclopedia of Bioethics* by Carol Spicer (1995) is the most comprehensive current collation of the content of professional codes.
2. For the AMA code, see American Medical Association, Council on Ethical and Judicial Affairs, *Code of Medical Ethics: Current Opinions with Annotations* (Chicago: American Medical Association, 1999).
3. Eliot Freidson's *Profession of Medicine* (New York: Dodd, Mead, 1973); Talcott Parson's "The Sick Role and the Role of the Physician Reconsidered," *Milbank Memorial Fund Quarterly* 257 (1975): 53ff.; and Renée C. Fox's *The Sociology of Medicine: A Participant Observer's View* (Englewood Cliffs, NJ: Prentice Hall, 1989) are excellent examinations of professions in general from the sociological point of view.
4. For the Hippocratic texts, the literature is enormous. For those with the requisite facility, the Greek text will be preferred. Of these I would single out the following: Loeb Classical Library, eight volumes in Greek and English, at present, with various translators (Cambridge, MA: Harvard University Press); *Hippocratic Writings*, trans. Frances Adams, in the Great Books of the Western World Series, Vol. 10 (Chicago: Encyclopedia Britannica, 1952).
5. Edelstein's *Ancient Medicine*, ed. Owsei Temkin and C. Lilian Temkin (Baltimore: Johns Hopkins University Press, 1967) represents the work of one of the most respected commentators on the Hippocratic corpus.
6. Paul Carrick's *Medical Ethics in Antiquity* (1985) is an excellent review of specific ethical issues as treated by ancient authors.
7. Owsei Temkin's *Hippocrates in a World of Pagans and Christians* (1991) is a study of the evolution of the Hippocratic ethos during the Christian era.
8. Wesley D. Smith's *The Hippocratic Tradition* (Ithaca, NY: Cornell University Press, 1979) is an essential commentary on the ways the Hippocratic tradition has been variously interpreted over the centuries and why. Robert Baker's "The History of Medical Ethics" (1993) is a concise, up-to-date history including later codes—for example, Percival, Gregory, and AMA.
9. Anthony Weston's *A Rule Book for Arguments* (1992) is a concise summation of proper and improper use of arguments in discussion.
10. The subject of codes of ethics appears periodically in almost every medical journal. Especially pertinent would be, for example: *Bulletin of the History of Medicine*, *Hastings Center Report*, *Kennedy Institute of Ethics Journal*, *Journal of Clinical Ethics*, *Journal of History of Medicine and Allied Sciences*, *Journal of Medicine and Philosophy*, and *Theoretical Medicine and Bioethics*.

Electronic resources include AMA Code of Medical Ethics (American Medical Association): www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.shtml; Bioethics Information Resources at the U.S. National Library of Medicine: www.nlm.nih.gov/bsd/bioethics.html; Center for the Study of Ethics in the Professions at IIT (Illinois Institute of Technology): www.iit.edu/libraries/csep/; ETHXWeb database (National Reference Center for Bioethics Literature, Kennedy Institute of Ethics, Georgetown University): http://bioethics.georgetown.edu/data

bases/ETHXWeb/basice.htm; UNESCO's Global Ethics Observatory (GEObs), which includes Database #5: Codes of Conduct: www.unesco.org/shs/ethics/geobs.

Note

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