PART I

AN INTRODUCTION TO THE HISTORY
OF MEDICAL ETHICS

Chapter 1

What Is the History of Medical Ethics?

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I. INTRODUCTION

This chapter's title is an interrogative: "What is the history of medical ethics?" Readers perusing the table of contents might be prompted to ask precisely this question. The expected chronological account seems hidden behind a façade of unfamiliar rhetoric about discourses, life cycles, and society. Our approach reflects a new era of scholarship on the history of medical ethics. Because readers may not be cognizant of the new scholarship, we introduce this volume with a chapter exploring the history of the history of medical ethics and the reasons why scholars have begun to take new approaches to the subject.

II. HOW OLD IS "MEDICAL ETHICS"?

Histories have to begin somewhere. The expression "medical ethics" was not coined until 1803, when Thomas Percival (1740–1804), a physician from Manchester, England, introduced it in his eponymous book *Medical Ethics* (Percival 1803b) as a description of the professional duties of physicians and surgeons to their patients, to their fellow practitioners, and to the public (see Chapters 18 and 36). As Percival was the first person to use the expression medical ethics, there is a sense in which the history of something designated medical ethics cannot predate

1803. Most historians, however, treat the history of medical ethics as coextensive with the history of medicine. They presume that it does not matter when the expression medical ethics was coined. As Juliet famously remarked, "What's in a name? A rose by any other name would smell as sweet." Yet Juliet continues, lamenting, "Romeo, Romeo, wherefore art thou Romeo! Deny thy father and refuse thy name!" Names matter. Words matter. They articulate conceptual frameworks, that is, the way in which people think about things. Juliet and Romeo would die because her family name was Capulet and his family name was Montague. In their world, one family was conceived as in opposition to the other. As the philosopher Ludwig Wittgenstein observed, *the limits of my language* mean the limits of our world" (Wittgenstein [1922] 1961, 115, Proposition 5.6). It is thus an open question whether a subject like "medical ethics" existed before it had a designation. Could medical ethics really have existed before 1803, if no one had used an expression designating this concept? Surely, anyone who wishes to extend the concept of medical ethics to eras earlier than 1803 needs to demonstrate that this extension makes sense.

Historians wishing to argue that the history of medical ethics predates Percival's invention of the expression could argue that equivalent terminology existed well before Percival invented his neologism in 1803. In 1563,

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for example, John Caius (1510–1573) inserted the term *moralibus* ("moral") into the title of the penal rules of the Royal College of Physicians of London (established 1518). These rules set penalties for members found guilty of publicly squabbling with fellow members, "stealing" their patients, or publicly accusing them of malpractice. Caius apparently inserted the term *moralibus* "out of respect for doctoral dignity" (Clark 1964–1966, 1:95). The English translation of Cauis's new title is "Ethical and Penal Rules." After 1563, therefore, medical practitioners sometimes characterized these rules as "ethical rules."

As it happens, however, we have no evidence of any earlier use of *moralibus* or its cognates in the context of Western medicine (Schleiner 1995, ix). One finds a variety of different terms in Latin and other languages that seem to play a role similar to medical ethics: *de cautelis medicorum* ("on rules of caution for physicians"), *decorum medici* ("the physician's decorum"), *déontologie médicale* ("medical deontology"), "gentlemanly honor," *jurisprudentia medica* ("medical jurisprudence"), *medicus politicus* ("the politic physician"), "religious duty," *savoir faire* ("know-how"), and so forth. Yet each of these terms seems to reflect concepts – prudence, decorum, duty, honor, jurisprudence, and know-how – that differ significantly from what Percival meant, and what we today mean, by medical ethics. One could thus legitimately construct a history of medical ethics that traced the ascendancy of the concept from 1803 to the present, with some reflections on its sixteenth-century antecedents, its sporadic evolution in nineteenth- and early twentieth-century America and Europe, and its mid-twentieth-century globalization. Such a history could relate how one particular conception evolved to provide the dominant conceptual framework and discourse for articulating the intersection of self-regulation, morality, custom, and medical conduct.

Some historians have explored this approach (Amundsen 2001, 126–27; see Chapter 28). More radically, some historians have even probed the notion that the concept of medical ethics and related notions such as informed consent are post-Holocaust phenomena, that is, concepts that gained currency in response to the 1947 Nazi doctors trial at Nuremberg. On this interpretation, the concept of medical ethics was valorized to distance and to distinguish "traditional," and presumably "ethical," medical practice from the "deviant and unethical" practices of Nazi physicians and medical researchers (Weindling 2001). For the most part, however, historians of medical ethics tend to hold that, although names may come in or out of fashion, the history of medical ethics dates back to the oaths of Caraka and Hippocrates and other ancient texts. They presume, without methodological reflection, an ancient lineage dating back to Babylonian, Chinese, Egyptian, Greek, Hebrew, and/or Sanskrit texts. How do historians justify this claim?

III. CONSTRUCTING HISTORIES OF MEDICAL ETHICS: SOME STRATEGIES AND THEIR PROBLEMS

1. Presentist Constructions of the History of Medical Ethics

Many historians of medical ethics make the "presentist presumption," that is, they assume that because we today have the concept medical ethics, people in other places and earlier eras must also have had a similar conception, and they construct their histories accordingly. Historian Martin Pernick characterizes this presumption as *presentism*, which he defines as "the anachronistic application of present assumptions to the past," which is problematic because it "obscures both change and continuity" (see Chapter 2). Presentism is anachronistic with respect to medical ethics because earlier medical practitioners who thought about matters we would deem medical ethics thought about them in terms of other concepts – decorum, honor, jurisprudence, prudence – that we no longer take to be directly applicable (Fissell 1993; see Chapters 18, 36, and 46). So the question remains: How can one extend the history of medical ethics to eras before 1803 or 1563?

2. Bioethicists' Pragmatic Constructions of the History of Medical Ethics

Bioethicists often brush off such methodological concerns by taking a pragmatic approach to history. Bioethics is a future-oriented and policy-driven field whose practitioners prefer to think in terms of historical narratives that serve to contextualize problems or "issues." These narratives engender a plot line that centers on problems and potential solutions. As Todd Chambers astutely remarks, this methodology permits bioethicists to frame the past to reflect their approach to the future (Chambers 1998, 20). This pragmatic problem-solving approach to history also serves as a typical framework for bioethicist-authored histories and historical anthologies (see, e.g., Reiser, Dyck, and Curran 1977).

Such pragmatic approaches seem to circumvent methodological questions generated by differences in linguistic and conceptual frameworks. Issues seem to endure, even if the conceptual frameworks and the language used to address them change. Yet, as several historians have pointed out, bioethicists' pragmatic issue-oriented constructions of history are rife with presentist presumptions (Amundsen 2001; Rütten 1996c). They presume that issues deemed "problematic" today would have been seen as problematic issues in earlier eras. They also presume that norms that we today accept as "solutions" to these problems were actually thought to address and/or to resolve these problems in the past. It is not obvious, however, that some issue, say trust in the patient–physician

relationship – an issue that came to be seen as problematic in an era of large-scale medical research, national health systems, and managed care – was considered equally problematic in earlier eras.

It is often claimed, for example, that the Hippocratic Oath addressed issues of trust in the physician–patient relationship (Pellegrino and Thomasma 1993; Veatch 1981). As it turns out, during the Roman era at least one first-century Greek physician, Scribonius Largus (fl. 14–54), a court physician to the emperor Claudius, adduced a line in the Hippocratic Oath as evidence of the trustworthiness of the medicines that Greek physicians prescribed for Romans. Romans distrusted Greek physicians not because they were *physicians*, but because they were *Greeks*, that is, aliens, who might use their Roman patients as human guinea pigs to test new drugs for potentially harmful side effects (Hamilton 1986; Temkin 1991, 59–61). Scribonius reassured Romans that the Hippocratic Oath prohibited killing, even killing the unborn. Thus, no Greek physician would prescribe a medication that might prove deadly to any patient.

Scribonius appealed to the oath to reassure Romans who suspected that Greek physicians might be untrustworthy; however, we have no evidence that Greeks distrusted their fellow Hellenes or that they used the oath to address this or some comparable problem of trust. In the absence of such evidence, one wonders whether bioethicists who portray the Hippocratic Oath as a solution to problems of distrust in Greek medicine are really reporting on a problem with an ancient pedigree or simply projecting a problem of the present day onto the past. To construct a history around a problem or issue, one needs evidence that it was a problem or issue in some earlier era and not one that appears real to us from our perspective but that never actually vexed those who lived in earlier eras. Absent such evidence, one has no justifiable grounds for interpreting norms, conventions, and texts from earlier eras as responses to particular problems.

To construct a history of medical ethics in terms of the continuity of issues or problems, one needs evidence that these problems were thought to exist in earlier eras, that they continued to exist, and that they are, in some sense, the ancestors of the issues and problems that we face today. In what is perhaps the first essay devoted to historiographic reflections on the construction of histories of medical ethics, historian Darrel Amundsen addresses the question of how best to establish a tradition with respect to some problem or issue. In doing so, he warns against two vices: presentism and essentialism. He defines the latter as "the tendency to see ideas . . . as free-floating in time and space . . . without reference to any temporal context other than the present, and . . . idea[s] . . . as essentially the same everywhere and at all times" (Amundsen 2001, 134). Amundsen puts the following questions to anyone who would claim that a tradition has arisen to address an issue:

Is there a discrete tradition in [a culture's] history regarding these issues? Is there evidence for counter-traditions plentiful enough to discard the concept of "tradition" in these areas? . . . When the behavior of [practitioners] seems to have been at variance with tradition, does that represent a counter-tradition or simply the reality of the inconsistency between ideals and practice? (Amundsen 2001, 140)

Few of those who have attempted to delineate the history of medical ethics in terms of so-called core issues, such as abortion, euthanasia, and trust have attempted to answer Amundsen's questions. Given the paucity of our knowledge on these subjects, it remains unclear whether any issue or tradition can truly be said to define the substantive core of the history of medical ethics from the beginnings of medicine to the present day.

3. Traditionalist Constructions of the History of Medical Ethics

No one conception of the intersection of medicine and morality clearly traces back to the beginnings of medicine. No common set of issues, problems, or traditions involving medicine and morality demonstrably forms one or more continuing threads that can be traced back to the earliest days of medicine. Why, then, is it commonly assumed that the history of medical ethics is coincident with the history of medicine itself? Perhaps the most compelling reason is precedent: This is how histories of medical ethics have traditionally been constructed. Evocations of precedent, however, merely recapitulate the question in a different form: Why have histories of medical ethics been constructed in just this way? Part of the answer lies in proclivities toward essentialism and presentism; another part lies in the third leg of this triad – traditionalism.

Traditionalism arises from the penchant to legitimate something by wrapping it in the mantle of ancient authority. In tradition-oriented eras and cultures, ancient lineage elevates the social status of ideas and practices. The more ancient and noble a heritage, the stronger is its claim to legitimacy. The past is thus appropriated to lay claim to the legitimating mantle of *tradition* for policies affecting the future. Just as contemporary bioethicists' historical frames reflect the pragmatic problem-solving orientation of the late twentieth-century society that nurtured the bioethics movement, earlier historical frames reflect the preoccupations of cultures that venerated tradition.

The objective of "traditionalist" histories and historical frames is to appropriate the authority of some tradition or of some revered figure – or some figure valorized to induce reverence – in an attempt to legitimate, or to delegitimate, policies or practices. Confucius, Galen, Hippocrates, Jesus, Maimonides, Muhammad, and numerous other cultural icons, as well as innumerable ancient

or sacred or revered texts, traditions, or sayings associated with them, have been pressed into service in historical frames designed to legitimate or to delegitimate a practice or policy (see, e.g., Cantor, 2002). In tradition-oriented societies, debates over new initiatives can focus more intently on the need to appropriate the legitimating authority of the past than on the future consequences of implementing the initiative. Thus, in nineteenth-century Spain the debate over whether to introduce new "French-style" empirical approaches to clinical medicine took the form of a dispute over whether or not these new approaches to clinical practice were more properly "Hippocratic" than then-current practices (see Chapter 33).

It is difficult to overestimate the role of traditionalist frames in the history of medical ethics. Before the twentieth century the *only* body of literature that might reasonably be characterized as histories of medical ethics or some presumptively kindred concept (*de cautelis medicourm*, *déontologie médicale*, *medicus politicus*, medical jurisprudence, etc.) was the literature of traditionalist frames. To make the same point more emphatically: Except for traditionalist historical frames and sundry traditionalist comments, there is no history of medical ethics or of any kindred concept before the early nineteenth century.

IV. CONSTRUCTIONS OF THE HISTORY OF MEDICAL ETHICS: A HISTORICAL PERSPECTIVE

1. Michael Ryan's Traditionalist Archetype

The first known text specifically to address itself to the history of something explicitly called medical ethics was written by Michael Ryan (1800–1841), a Dublin- and Edinburgh-educated, London-based Irish obstetrician, who was also the first person to style himself a "professor of medical ethics" (Ryan 1831a, 1832). From the 1820s through the early 1830s, Ryan began to offer lectures on medical jurisprudence, which included a set of lectures on medical ethics and its history. He published them in a monograph titled *A Manual of Medical Jurisprudence* (Ryan 1831b, 1832). Ryan held that medical ethics was properly a preliminary to medical jurisprudence. He asked his audience of medical students, "Is it not a matter of astonishment that medical students in every part of this empire never hear a single observation during their education on the ethical duties they owe the profession and the public?" He continued, "A man who obtains the degree of M.D. is . . . ignorant of medical ethics . . . he is ushered into practice without the slightest acquaintance with the moral and delicate duties which he has to perform." "Hence," he concludes, "the dishonourable conduct for which the profession in this age is so remarkably distinguished, and . . . the chief cause of the humiliation and degradation of the noblest of human sciences in the estimation of the public." If only "students [were] duly informed o[f] the duties and responsibilities they owe the profession and the public, those disgraceful private disputes, and those disreputable blunders made in our courts, would be of rare occurrence" (Ryan 1831b, 2).

Ryan taught that knowledge of medical ethics was properly preliminary to understanding medical jurisprudence because ignorance of medical ethics was a leading cause of the sort of dishonorable practitioner conduct that ended up in courts of law. As to the subject matter of medical ethics, "the only essays we have on medical ethics are those of Drs. Gregory and Percival" (Ryan 1831b, 2–3). Yet, instead of commending Gregory and Percival as innovators, Ryan insinuated an ancient pedigree for the new concept of medical ethics:

> There never was a period in medical history in which ethics was so neglected and violated as in this present "age of intellect". . . . It is, therefore, necessary, to inform rising members of the profession, of those virtuous and noble principles which regulated the professional conduct of their predecessors, and procured that unbounded confidence and universal esteem bestowed on them by society *in every age and country*. (Ryan 1832, 12, emphasis added)

Notice that medical ethics is portrayed as a source of professional esteem and "in every age and country" – except for the present age.

Instead of claiming that Gregory and Percival had invented a new but sadly neglected conception, Ryan projected their ideas onto the past. He laid out a plot line that would have been familiar to his audience: the fall from grace and the path to redemption – at least for those adhering to the "traditional wisdom" propounded by Gregory and Percival. To mute the conflict between this traditionalist claim and his earlier observation that "the only essays we have on medical ethics" are those of Gregory and Percival, Ryan broadens his characterization of medical ethics. The subject now extends to "virtuous and noble principles which regulate professional conduct," a conception that enables Ryan to find a common thread tying Gregory and Percival to Hippocrates. "The duties and qualifications of medical men were never more fully exemplified," Ryan continues, "than by the conduct of Hippocrates or more eloquently described than by his own pen" (Ryan 1832, 12). Having made this connection, Ryan discusses the character of Hippocrates and the Hippocratic texts, tracing medical ethics through the "Middle Ages" until he reaches a chapter on "Ethics of the Present Period." Ryan's chronological narrative thus portrays Gregory and Percival as heirs to cumulative wisdom of the ages and casts their writings as the apex of traditional wisdom on professional character and conduct. The precedent for presuming that the history of medical ethics is coextensive with

the history of medicine itself was thus set in the very first work on the history of the subject.

We do not know what motivated Ryan's recourse to traditionalism: a felt need to cope with the waning influence of Gregory and Percival in Britain; the social aspirations of the young medical professionals to whom he was lecturing; a propensity toward traditionalism widespread in the culture of the period; or, perhaps, a desire to seek the unity of ideas in their origins? His traditionalist framework set the precedent for future histories of medical ethics. The standard history of medical ethics would thereafter emphasize oaths, codes, rules, principles, and other formalizations of medical self-regulation, underlining that they were founded on ancient traditions that are continuous and influential to the present day.

2. Traditionalism and Modernism: Differing Approaches to Constructing History in Medical Ethics and in Science

To appreciate the influence of the traditionalist archetype on our understanding of the history of medical ethics, compare the construction of histories of science with the construction of histories of medical ethics. Like medicine and medical ethics, science can produce an ancient pedigree. Yet, modern science, including modern medical science, tends to be presented as an artifact of the Enlightenment. None of the major figures in what has been denominated "the scientific revolution" – Galileo, Harvey, Newton, and their colleagues – is represented as perpetuating the wisdom of the past. As Roy Porter (1946–2002) put it, in their hands, "The Enlightenment secured a radical new rendering of the constitution of Nature" (Porter 2000, 138).

John Gregory and Thomas Percival were Enlightenment thinkers; neither sought to wrap himself in the legitimating mantle of ancient Hippocratic authority. Although clearly aware of the Hippocratic corpus, they seldom mentioned it and never treated it as authoritative. Gregory, in particular, scorned physicians who approached medicine with a "warm admiration of antiquity which . . . attached physicians to the ancient writers in their own profession" including the "blind and stupid admiration of Hippocrates" (Gregory [1772b] 1998b, 146). Gregory and Percival believed themselves to be creating a new ethics for a new medicine that was appropriate to a new and more enlightened age. Had the history of medical ethics been constructed following the pattern of histories of science, the plot line of the narratives about these eighteenth-century figures would center on the "invention of professional medical ethics" (McCullough 1998a) or "the medical ethics revolution" (Baker 1999, 2002a). Certainly, Gregory and Percival would have wished their work remembered in this way. Yet, ironically, the traditionalist archetype presents them, not as founders of the new,

but as conservers of the old, and, in striking contrast to the history of science, the history of medical ethics is typically narrated as the story of the conservation of ancient traditions.

3. Inverting the Ryan Archetype: The History of Medical Ethics as Delegitimation

In one of those odd pranks of history, professional historians have tended to portray Gregory and, especially, Percival not as innovators, or even as purveyors of a tradition, but as conservative defenders of the status quo. The tradition of constructing delegitimating histories, that is, histories that invert Ryan's intent but otherwise hew to his traditionalist construction, originates in the 1880s in the context of a debate over the legitimacy of the American Medical Association's (AMA's) Code of Ethics (Post 1883). Nathan Smith Davis (1817–1904), sometimes called "the father of the American Medical Association" and a former president of the organization, defended the organization and its code of ethics by writing a history of medicine that made the AMA's Code of Ethics an apical achievement of modern medicine (Davis [1903] 1907).

Davis had the "last word" for only two decades. His views on the significance of the AMA's Code of Ethics were challenged by Chauncey Leake (1896–1978), president, at different points in his life, of four influential institutions: the American Pharmacology Society; the American Association for the Advancement of Science; the American Association for the History of Medicine; and the History of Science Society. Leake's scholarly voice was one of the most influential of his era, especially among historians of medicine and science.

Motivated by animus against the AMA, which, in his view, was abdicating its moral and social responsibilities by successfully disguising "trade union rules" as a code of ethics, Leake tried to demonstrate that codes of professional medical ethics typically serve to mask professional avarice and privilege. Correctly tracing the origin of the AMA's Code of Ethics back to Percival's *Medical Ethics*, Leake laid blame for this semantic charade at Percival's feet. "The term 'medical ethics' introduced by Percival," Leake charged, "is really a misnomer; it refers chiefly to the rules of etiquette developed in the profession to regulate professional contacts of its members with each other" (Leake 1927, 2). Worse yet, Leake charged, "subsequent systems of general professional advice, whether official or not, have received the same title. As a result, confusion has developed in the minds of many physicians between what may be really a matter of ethics and what may be concerned with etiquette" (Leake 1927, 2).

Genuine ethics, according to Leake, is "concerned with ultimate consequences of the conduct of physicians toward their individual patients and toward society as a whole"; it should also include "a consideration of the will

and motive behind this conduct" and should be predicated on "analyses of ethical theory made by recognized ethical scholars" (Leake 1927, 2–3). Insofar as practitioners' self-regulatory schemes are not applications of a recognized ethical theory, insofar as they deal with intrapractitioner relationships, and insofar as they eschew discussions of motive and consequences, they are mere "medical etiquette." Leake thus concluded that Percival's *Medical Ethics*, the paradigm for all professional medical ethics and the model for the AMA's Code of Ethics, was really etiquette, "trade union rules," parading as ethics. The history of medical ethics, he held, is really the history of this charade, and the medical historian's mission was to unmask it.

Leake's conception of the professional historian as unmasker of professional medical ethics was well received by later generations of medical historians, in part because it was congruent with the social history of medicine paradigm that emerged in the 1940s. This movement (Porter D, 1995) was pioneered by such figures as the Swiss-American medical historian Henry Sigerist (1891–1957; see Sigerist 1940). Following Sigerist, social historians of medicine strove to bring social science perspectives to bear on the history of medicine and to broaden both the sources and the scope of the history of medicine so that it embraced perspectives other than those of elite practitioners. Social historians of medicine were thus inclined to be sympathetic toward Leake's views and sought to advance his project through a social scientific unmasking of medical ethics. This became the received approach to the history of medical ethics among professional social historians of medicine (see, e.g., Konold 1962).

In 1975, two sociologists, Jeffrey Berlant (1975) and Ivan Waddington (1975), updated Leake's analysis. Although their positions differ (see Waddington 1984), both took aim at the then-dominant functionalist theories of professionalism championed by such sociologists as Talcott Parsons (1902–1979). Functionalists justify the prerogatives of professions as necessary requisites and suitable rewards for the services that they offer to society. Berlant and Waddington attempted to deconstruct this scenario by arguing that professions asserted ethical claims as fig leaves to disguise assertions of monopolistic privileges "to the powers that be and to the public." Berlant's formulation of the theory treats Percival as "a naively saintly man" (Berlant 1975, 56) whose "ethics were . . . the organizational tool . . . for monopolistic traditions for all professions, [and] an important device for suppressing competition between different types of professions" (Berlant 1975, 59).

Many social historians embraced this analysis. It fit their conception of the medical historian's role as "demystifying rhetorics, representations, and power relations in medicine . . . defrocking doctors, and 'unmasking' medicine as a 'political enterprise' . . . exposing the cultural relativity of truth, rationality, ethics and morals" (Cooter 1995, 260). The fig leaf thesis also attracted American physicians disillusioned with the AMA's lobbying efforts against Medicaid and Medicare programs (which provide health insurance for the medically indigent, the disabled, and citizens older than the age of 65 years) and its efforts to stymie plans for a national health insurance plan for the United States. Disgusted, one of America's leading physicians, Carleton B. Chapman (1915–2000), wrote a comprehensive delegitimating global history of medical ethics.

Like Leake, Chapman had been dean of a medical school (Dartmouth), and president of a national organization (The Commonwealth Fund). His book, *Physicians, Law and Ethics* (Chapman 1984), began in Mesopotamia and ended with the ethics of the AMA as of 1980. Throughout, Chapman hewed to an inverted Ryan archetype, emphasizing that principles or norms of practitioner self-regulation were founded on ancient traditions continuous and influential to his day. In era after era, however, Chapman found that professional medical ethics was self-serving and monopolistic. As to the book that started it all, *Medical Ethics*, its "chief aim . . . is to enhance the honor and dignity and security of the profession itself" (Chapman 1984, 85).

4. Challenging Delegitimating Histories of Medical Ethics

Even as the fig leaf/monopolization theory gained advocates among dissident physicians and social historians of medicine, medical humanists and nascent bioethicists were developing a different reading of Percival and of codes of professional ethics. In the 1970s the medical humanities movement – an international interdisciplinary effort to broaden the scope of medical education by including the humanities and social sciences – began to take concrete form in medical humanities institutes and programs established at medical schools in the United Kingdom, the United States, and South America (see Chapters 39 and 42). These institutes were located in medical schools, and their faculty was charged with discussing the history and morality of medicine. Approaching Percival from this perspective, Chester Burns (1937–2006) of the Institute for Medical Humanities (Galveston) and Edmund Pellegrino of Georgetown University found the then-current Leake-influenced delegitimating reading of *Medical Ethics* unsustainable. Their groundbreaking commentaries undermined the fig leaf/monopolization theory by showing that the text of *Medical Ethics* satisfies all of Leake's criteria for "genuine medical ethics" (Burns 1977b; Pellegrino 1985).

Scholars associated with the nascent bioethics movement also read Percival differently. As one historian tells the tale (Rothman 1991), the movement began with a 1966 whistle-blowing article by Harvard Medical School

professor Henry Beecher (1904–1976) that indicted twenty-two experiments for violating the rights of the individuals subjected to the research (Beecher 1966). Four years later, Beecher constructed a traditionalist historical frame for his proposed reform of human subjects research by reprinting sections from historic documents on the regulation of experiments on human subjects (Beecher 1970). A section from *Medical Ethics* was reprinted as a pioneering work in research ethics:

> It was evident [to Percival] 166 years ago that [experiments] must take place only when "scrupulously and conscientiously governed by sound reason, just analogy, and well authenticated facts" [Percival 1803, Chap. I, Art. XII] . . . and that the innovator must, prior to the study, consult with his peers. Echoes of all of these points are present in most up-to-date codes. (Beecher 1970, 218)

The leading figure in the movement to reform human subjects research ethics was aptly citing a 166-year-old passage from Percival's *Medical Ethics* as anticipating the ethical safeguards found in "the most up-to-date codes." In this context, the dismissal of *Medical Ethics* as mere "etiquette" or a "fig leaf" was dubious.

Other scholars associated with the nascent bioethics movement also read *Medical Ethics* as real ethics. Another reformer, Jay Katz, wrote "*Medical Ethics* set forth principles of broad ethical significance to society and humanity. . . . Percival urged his colleagues to be solicitous of their patients' welfare and to provide good custody: 'Every case, committed to the charge of a physician or surgeon should be treated with attention, steadiness and humanity' [Percival 1803, Chap. II, Art. I]" (Katz 2002, 17). Like Beecher, Burns, and Pellegrino, Katz found in Percival, not an apologist for the status quo, but a fellow reformer (Katz 1969, 486–87; 1972, 321). An interpretational cleavage was thus forming: On one side were bioethicists and medical humanists who found in Percival a kindred moral spirit; on the other were professional social historians of medicine who continued to hew to Leake's agenda of "unmasking" medical ethics, especially Percival's and the AMA's.

5. Evolving Patterns in the Construction of Histories of Medical Ethics 1970s to 1990s

In the late 1970s, as the medical humanities and bioethics movements began to merge, collections of historical materials were compiled to "use in the classroom" (Burns 1977a, 1) and for "teaching medical ethics to undergraduate and graduate students at Harvard University" (Reiser, Dyck, and Curran 1977, xiii). Two major collections were published to support the new pedagogy: Chester Burns' *Legacies in Ethics and Medicine* (1977a) and the collaboration by Stanley Reiser, Arthur Dyck, and William Curran, *Ethics*

in Medicine (1977). Both anthologies used traditionalist constructions, treating the history of medical ethics as "the history of . . . professional ideals and their associated values as they have been discovered and claimed from antiquity to the present day" (Burns 1977a, 1) and as "the development of medical ethics as a form of professional self-regulation [that] has a history as long and as venerable as the history of medicine itself from the Hippocratic Oath" (Reiser, Dyck, and Curran 1977, 1).

Ethics in Medicine focuses on primary sources and constructs its history around such enduring "issues as abortion, euthanasia, triage, eugenics and the cost-effectiveness of medical procedures" (Reiser, Dyck, and Curran 1977, 1). *Legacies* reprints historical studies of professional self-regulation. These articles represent an important scholarly tradition in which materials dealing with the normative dimensions of medicine – particularly oaths and codes – are analyzed for the insights that they offer into practitioners' belief systems and standards of conduct. This tradition traces back to critical debates among such German-trained scholars as Karl Deichgräber (1903–1984), Ludwig Edelstein (1902–1965), and Hans Diller (1905–1977), who debated the authenticity, date, and significance of the Hippocratic Oath (Deichgräber 1955; Diller 1962; Edelstein 1967; Jones 1924). Some major scholars working in this tradition, although not necessarily on the Hippocratic corpus, include Darrel Amundsen (Amundsen 1996; see Chapters 7 and 12), Lester King (King 1958), Owsei Temkin (1902–2002) (Temkin 1991), Vivian Nutton (see Chapter 23), Heinrich von Staden (see Chapter 24), and Chester Burns (see Chapter 31).

In 1978, a year after these trail-blazing anthologies were published, the field of the history of medical ethics was transformed by the publication of a 97,000-word section on "Medical Ethics: History of," edited by the eminent bioethicist Albert Jonsen for Warren Reich's *Encyclopedia of Bioethics*. Within this section were twenty-nine commissioned articles (Reich 1978, 1995; Post 2004). Like *Ethics in Medicine*, Jonsen's section of the *Encyclopedia of Bioethics* was constructed in terms of "issues." The *Encyclopedia's* extensive treatment of the history of medical ethics centers on a chronologically ordered, geographical account of the history of medical ethics in "Primitive Societies," "Near and Middle East and Africa," "South and East Asia," and "Europe and the Americas."

The sheer bulk of the "Medical Ethics: History of" served a traditionalist legitimating function, not only for the field of bioethics, but also for the encyclopedia itself. The four-volume work was published before bioethics was a recognized field and before the neologism "bioethics" (coined in 1971) was recognized in standard dictionaries (Reich 1994, 1995b). Reich thus had to justify creating an encyclopedia for a field in the earliest stages of its formation. The "long history" of medical ethics provided a perfect justification: "Although it is unusual, perhaps

unprecedented, for a special encyclopedia to be produced almost simultaneously with the emergence of its field . . . many of the issues . . . are not new; they were waiting to be gleaned from centuries of literature in the fields of philosophy, medical ethics, history of medicine and other fields" (Reich 1978, xvi). Thus Ryan's notion of the long history of medical ethics, reconfigured in Jonsen's issues-based geochronological construction of the history for medical ethics, helped Reich to justify the "perhaps unprecedented" coemergence of an encyclopedia with its field.

The Jonsen–Reich view that "a central concern of bioethics is the entire history of medical ethics" (Reich 1978, 876) was unusual in the problem-driven, future-oriented field of bioethics (and remains so to this day: see Baker 2002a; McCullough 1998b, 2–3), but it was fortunate for the history of medical ethics. The historical entries in the encyclopedia served as a catalyst for the career interests of a significant subset of the scholars who wrote them. It is noteworthy that several of the contributors to this volume, including both editors, wrote historical articles for the first edition of *Encyclopedia of Bioethics* (Amundsen 1996, viii; Baker 2002b, 376–77; McCullough 2002, 362–63).

Historical scholarship during this period was not exclusively Anglo-American. As the medical humanities and bioethics movements spread, they promoted early compilations and histories of medical ethics in various scholarly traditions (see, e.g., Unshuld 1979). One of the most important of these was Pedro Laín Entralgo's *El Médico y el Enfermo* (Laín Entralgo 1969a) [translated as *Doctor and Patient* (Laín Entralgo 1969b)], perhaps the first attempt to explore the history of the physician–patient relationship.

6. Beyond Traditionalism: The Scholarly Explosion of the 1990s

In the 1990s, research and publication on the history of medical ethics and bioethics expanded exponentially. More articles, commentaries, and monographs were published in this decade than in the 166 years since Ryan first lectured on the subject. Much of the impetus for histories of medical ethics can be traced to a newfound interest in the history of bioethics itself. The first historical case-based textbook of bioethics began publication in the 1990s (Pence 1990, 1995, 2000, 2004). Two major monographs on the history of bioethics and the first monograph on the global history of medical ethics were published in this decade (Jonsen 1998, 2000; Rothman 1991). These accounts of the birth of bioethics tend to focus on its conception, growth, and success, first in the United States (see Chapter 38) and then elsewhere (Chapters 39–45).

Although they differ in detail, the initial histories of bioethics tend to portray it as a response to the research scandals of 1970s and to the problems associated with such new medical technologies as assisted reproduction, cardiopulmonary resuscitation, dialysis, organ transplantation, ventilators, xenografts, and so forth. They also underline the role of an interdisciplinary mix of clinicians, lawyers, philosophers, scientists, social scientists, and theologians in pronouncing on these issues and take note of the ultimate displacement of these multidisciplinary discourses by a common "bioethical" discourse, a pidgin that draws on aspects of all these fields but depends heavily on argument forms and discourse styles derived from analytic philosophy (see Chapter 36; Evans 2002).

For the most part, the narrative line around which these histories are constructed is that of a morality tale. They open with portrayals of the excesses of the mandarins of an exponentially expanding biomedicine running amuck in self-importance. Unelected, unaccountable, and unresponsive, these elites treat the institutions of biomedicine as private fiefdoms – resisting calls for accountability by either religious authorities or public funding sources. Patrons, politicians, and the public react by championing a new field, bioethics, whose mission was essentially democratic: holding the biomedical elite accountable to broader cultural and religious values and to the interests of patients and the public. Some accounts theorize that the recruits for the new discipline were drawn from elements of the liberal intelligentsia energized by the American civil rights and anti–Vietnam war movements and by the democratizing antiauthoritarian forces of the 1960s. As these intellectuals critiqued medicine, they naturally transposed the moralizing language of the 1960s movements into the clinic and onto government commissions, moving, as it were, from civil rights to patients' rights.

As soon as these initial histories of bioethics were published, however, dissent arose over their tenor and content. Bioethicists from other countries objected to the emphasis on the American roots of bioethics (see Chapter 39; Campbell 2000) and their failure to recognize that, as bioethics became internationalized, Asian, European, and Latin American bioethicists began to develop alternatives to the autonomy-based conception of bioethics prevalent in America (see Chapters 39–45). Closer to home, anthropologists, sociologists, and historians trained in the Leakean tradition of "unmasking" medical ethics began to challenge the morality-tale structure of these narratives. Instead of serving as watchdogs policing the moral bounds of biomedicine, these critics proclaimed bioethicists "lapdogs," legitimating the cultural authority of medicine, medical technologies, and dominant ideals of (White Anglo-Saxon Protestant male) American culture (Cooter 1995; DeVries and Subedi 1998; Evans 2001; Stevens 2000). The debate over the unmasking of medical ethics that had preoccupied commentators in the 1970s and 1980s was thus recast as the unmasking of bioethics.

Scholarship on the history of traditional medical ethics also expanded exponentially in the 1990s. Three volumes

based on conferences supported by the Wellcome Trust were pivotal. *Doctors and Ethics: The Earlier Historical Settings of Professional Ethics*, a collection of papers by professional historians of medicine, opens with the astute observation that "perceptions of the 'ethical' have changed greatly in the past" (Wear, Geyer-Kordesch, and French 1993, 1). The volume's editors and contributors touch on the complexity of constructing the history of medical ethics. In his chapter on philosopher-physician Gabriel de Zerbi (1445–1505), for example, editor Roger French (1938–2002) observes that it is not "unproblematic, that medical ethics have a history." He also remarks that "one must . . . address problems that looked ethical to [earlier ages], but not necessarily to us" (French 1993, 72). It is thus a testament to the enduring power of traditionalism that the editors nonetheless pay deference to the idea of a "long tradition" of medical ethics in their prefatory remarks. "Medical ethics," they remark, "were a constant part of the history of medicine." Their volume merely "tackles the gap on the subject that exists between" the Hippocratic Oath and Percival's *Medical Ethics* (Wear, Geyer-Kordesch, and French 1993, 1).

A more concerted challenge to traditionalist readings of the history of medical ethics was mounted in other Wellcome conferences. The organizers were Robert Baker and Dorothy and Roy Porter – longtime friends and sometime colleagues – who had worked at the Wellcome Institute for the History of Medicine in London (Baker, Porter, and Porter 1993; Baker 1995). The volumes open with the observation that "medical [ethical] issues . . . have never been timeless" (Baker, Porter, and Porter 1993, 2). Mary Fissell – Baker's carrel mate at Wellcome – challenged traditionalist presumptions of continuity:

> While the shade of Hippocrates looms large in our current assumptions about the roots of medical ethics, early modern medical practitioners rarely looked to antiquity for guidance. Indeed, no ethics particular to their profession or vocation governed conduct. Rather, appropriate behavior was inculcated through the institution of apprenticeship, shaped by general norms of master/servant and client/patron interactions. It was only in the 1770s that a medical ethics became possible or desirable, following changes in the structure of medical practice and shifts in more general cultural assumptions. (Fissell 1993, 19)

In an introductory section, Baker's editorial comments draw out some implications of Fissell's claims:

> The dominant myth in the history of medical ethics is that of the Hippocratic footnote, the idea that the foundations of Western medical ethics were laid down in the Hippocratic Oath . . . and . . . the history of medical ethics from that time to the present is a series of comments . . . on premises laid down in

the Oath . . . It is . . . difficult, as Mary Fissell points out . . . to reconcile the purported dominance of Hippocratic morality with the absence of any specific mention of the Oath or the aphorisms [in eighteenth century cases and texts]. (Baker 1993b, 16)

Focusing on specific cases and texts, contributor after contributor to the *Codification* volumes (Baker, Porter, and Porter 1993; Baker 1995) emphasize the diversity of alternative conceptions of standards of practitioner conduct, including *casus conscientiae* (cases of conscience), decorum, dispute behavior, medical jurisprudence, *theologia moralis*/moral theology, requisites of patronage, unwritten juridically enforced standards of "infamous conduct," and, of course, medical ethics. Joining Baker and Fissell in raising questions about presumptions of continuity in the history of medical ethics are bioethicists Laurence McCullough and Robert Veatch and medical historians Peter Bartrap, Johanna Geyer-Kordesch, David Harley, John Pickstone, and Russell Smith. The *Codification* volumes thus challenged the prevailing presumption that the history of medical ethics could be constructed in terms of some one continuous conceptualization or some standard set of issues internal to medicine and descended intact from the Hippocratic era.

Around the same time, Winfried Schleiner also began to reflect on the discontinuous nature of the history of "medical ethics." As a preliminary to constructing a history of Renaissance "medical ethics," Schleiner consulted the "catalogue of the . . . Herzog August Biblitothek . . . generally an indispensable tool for a thematic access to the field of Renaissance medicine," only to discover that "it has no entry for 'Ethik' [Ethics]" (Schleiner 1995, ix). Schleiner thus had to construct a concept of medical ethics for an era that lacked one. The earliest treatises that he found on something akin to medical ethics had been written by nominally Christianized Jewish physicians from Portugal known as "Lusitani." Needing to function in an adamantly Christian and openly anti-Semitic world, these Lusitani physicians turned to secular humanism as an alternative to religiously based ideals of morality in relation to medical conduct. Schleiner quotes a passage from *Medicus-Politicus: Sive, De Officiis Medico-Politicis Tractatus* (*The Politic Physician: Or A Treatise on Medico-Political Duties*) (de Castro 1614) by Rodrigo de Castro (1564–1627; pseudonym Amatus Lusitanus) as an example of the Lusitani search for a nonreligious humanistic basis for medical conduct: "[W]hoever is requesting individual medical care, the physician should take that person up and attempt to cure that person with all diligence, whether Christian, Jew, Turk, or heathen; for all are linked by the law of *humanitas*, and *humanitas* requires that they all be treated equally by the physician" (Schleiner 1995, 77).

For these Lusitani physicians, therefore, the law of humanity – Ciceronian Stoic humanism – and not religion