

# Medical Professionalism: A Parsonian View

STEPHEN R. LATHAM, J.D., PH.D.

## Abstract

This paper argues for a normative conception of medical professionalism based on the work of sociologist Talcott Parsons. Such a conception grounds medical professionalism on the expert authority of the physician; the concept of “authority” is therefore discussed at length. Parsons’ view also lays much stress on the fact that the proper exercise of medical authority nearly always involves aligning the interests of individual patients with those of society at large. Parsonian professionalism looks to professional institutions such as medical schools, societies and journals to secure the competence and ethical behavior of professionals, and to help ensure that professionals’ exercise of authority is never biased by private financial interests or by public political power. Professional institutions should encourage professionals to develop a set of preferences and desires (e.g., for respect of their peers, and not for power or financial gain) that will tend to make them trustworthy authorities.

**Key Words:** Professionalism, medical profession, authority, patient and society, Talcott Parsons.

---

THERE IS ONE WAY of describing professions — a way that became current in the sociological literature of the mid-1900s — which we might term the “checklist” method. This method identifies an occupation as a profession if:

- Participation in it requires formal education;
- Its members enjoy control over their own occupational training standards and their own disciplinary mechanisms;
- There is a scholarly journal devoted to its standards;
- Its practitioners enjoy relatively high social status;
- Its practitioners have secured protection from state regulation as well as from market pressures; and so on.

The checklist method permits and even encourages ongoing debate about whether certain

occupations “count” as professional, e.g., librarianship, social work and journalism. It also allows for speculation about the ability of occupations to acquire social status by “professionalizing” themselves through the acquisition of the various items on the checklist (1).

This checklist approach has some decided peculiarities. First, it gives ontological priority to occupational groups rather than to particular practices. It is professional groups or associations, after all, that can issue educational standards, publish journals, and so on. The checklist approach holds, in other words, that the title “profession” attaches not to particular kinds of work, but to a particular kind of social organization of work; that a professional association is not a union of persons who were, antecedently, professionals, but instead that persons can be professionals only insofar as they belong to professional associations. The second peculiarity of the checklist approach is that it describes professions in purely positive terms, when our ordinary uses of the word — “He’s a real professional. She did a professional job. This isn’t just my job, it’s my profession” — have a decidedly normative cast.

As a matter of history-of-sociology, the checklist approach was the tail-end contribution

---

Address correspondence to Stephen R. Latham, J.D., Ph.D., Director, Center for Health Law and Policy, Quinnipiac University School of Law, 275 Mount Carmel Avenue, Hamden, CT 06518.

Presented at the Issues in Medical Ethics 2000 Conference at the Mount Sinai School of Medicine, New York, NY on November 3, 2000.

of the structural/functionalist school of sociological thought about the professions — a school named for its belief that the structures of social institutions could be explained by the social functions they served. The founder of that school was Talcott Parsons — a man whose work dominated 20th century sociology in a way nearly unparalleled in any other field. (We might compare him to Noam Chomsky in linguistics.) In what follows, I propose that we re-introduce ourselves to the original Parsonian conception of a profession — a conception which gives ontological pride of place not to groups, but to the important work done by those groups' members, and which describes professionalism not just in organizational, but in moral, terms.

Parsons was not only a sociologist, but also a translator — the first person to translate Max Weber's monumental works of sociology into English (2). And it was in the course of his translation of Weber that Parsons' attention was first turned to the professions. He was working through Weber's discussion of the types of legitimate authority. One's authority, in Weber's view, was essentially the probability that one's commands would be obeyed. Weber located three varieties of legitimate authority: legal authority, in which people obey your commands because they recognize the legal legitimacy of your having issued them; traditional authority, in which people obey your commands because they have always done so; and charismatic authority, in which people obey your commands because something in your personality emotionally compels their obedience (3).

Parsons worried over this typology; he felt that Weber had missed a fourth, and important, variety of legitimate authority. This was expert authority: people obey your commands because they believe that you know something they don't know. This kind of authority Parsons explicitly associated with professionals.

In later essays, Parsons expanded upon the role of professional authority in maintaining modern society (4–6). Professionals, Parsons believed, were essentially double-agents or, if you prefer, “interstitial go-betweens.” Their job was to use their authority to mediate between individuals — their clients — and society as a whole. Part of the time, they used their authority to curb their own clients' deviance — to align their clients' interests and actions with broad social norms. In this vein, we may think of the lawyer who scolds his corporate client into obeying environmental regulations, or the doctor who works to heal his patient in order

that he might return to work and to his other social obligations. In each case, the “deviant” client is “mainstreamed” through the intercession of the professional. On the other hand, professional authority is sometimes used to create safety zones for individuals against the demands of social norms. Examples of this include the lawyer who goes to court to defend his client's unconventional religious practices, or the physician who writes a note excusing his sick patient from having to go to work. Professionals, in Parsons' view, are therefore constantly invoking their authority to negotiate and re-negotiate the normative boundaries between individuals and society.

Now, this project of interstitial negotiation can be successful — and in Parsons' view, has been successful — only when professionals maintain a certain outlook. Professionals, Parsons thought, must not be too strongly motivated by the desire for power, lest they attempt to achieve it by promoting social norms at the expense of individual liberty. On the other hand, they must not be too strongly motivated by profit, lest they allow their authority to be bought out by wealthy private clients seeking exemption from social norms. Instead, Parsons concluded, the professional project is successful only because professionals are motivated primarily by the desire for status and reputation — both among their peers and in society at large — rather than by the desire for money or power.

And it is because professionals are thus motivated that professional institutions — societies and university departments, publications and clubs — emerge as powerful socializers of professionals. It is not the existence of those institutions that first marks the professional as professional; they appear after the professionals do. But the existence of such institutions, by encouraging peer review and offering opportunities for professionals to compete for respect among themselves and before the public, does help assure that professional authority is exercised for the social good, in a way that keeps individual and community interests in proper balance. The “pro-fession” of professionalism — its “speaking forth” — thus occurs in the public articulation by and through professional institutions of the profession's standards, both technical and moral. Importantly, these standards, though they may be articulated by the profession through its institutions, are not simply the profession's private property — not, as it were, Masonic mysteries. In order both to properly socialize professionals and to inspire the pub-

lic's trust and respect, the profession's standards of competence and ethicality must be fully acceptable and to a large extent be transparent to the public.

Here, then, are the core elements of a Parsonian profession: a profession is an occupation that uses its legitimate expert authority to mediate between individuals and society. (Here we can take a page from Kant (7), and note that physicians mediate between physical man and his society; lawyers between civil man and his society; and clergy between spiritual man and his society.) A profession's members are characteristically peer-oriented and status hungry, but not profit-motivated and not motivated by desire for political power. Their professional institutions socialize them for proper service in their interstitial role, and give them the opportunity for acts of profession before one another and society at large. These acts of profession both socialize the professionals and inspire trust from the public, facilitating the safe exercise of professional authority.

The Parsonian model of professionalism was torn apart by critical scholarship in the 1960s and 1970s. Critics argued — persuasively, I think — that the Parsonian view had ignored the exploitative actions of professional monopolists, who were in fact hungry not merely for status but also for both money and power; and, moreover, that it had ignored the actual failure of professional institutions to guarantee the quality of their members' work (8, 9). Finally, critics of the medical profession have pointed out that even physicians' expert authority is something of a sham: much medical practice is not based on scientific evidence, is not as uniform as truly scientific practice ought to be, and is heavily influenced by economic and marketing forces (10).

Nonetheless, even if the Parsonian model fails as a factual description of medical professionalism in America, I believe that there is much to recommend it as a normative description of what American medical professionalism ought to look like. Let us take a closer look at each of its elements to see why. I shall begin with a closer look at the nature of professional authority, and then make brief comments about the interstitial role of professionals, their motivations according to the Parsonian model, and their acts of profession.

### The Authority of the Medical Profession

At the base of the Parsonian view is the idea that the authority of professionals is grounded

in their knowledge and expertise. Our inquiry will be more precise if we pause for a moment to consider, more carefully, just what we mean when we speak of the professional's authority. Consider the following preliminary definition: One has authority if one's statements give others new and sufficient reason for holding a belief or taking an action.

Understanding the full import of this definition requires us first to note the two-fold distinction of authority on the one hand from force, and on the other from persuasion. According to Hannah Arendt, that two-fold distinction goes back to the origins of the concept of authority in Plato's writings. Plato, Arendt asserts, wanted to establish a form of rule in the polis which was "an alternative to the common Greek way of handling domestic affairs, which was persuasion, as well as to the common way of handling foreign affairs, which was force and violence" (11). Authority's hallmark, she notes, is "unquestioning recognition by those who are asked to obey; neither coercion nor persuasion is needed. (A father can lose his authority either by beating his child or by starting to argue with him, that is, either by behaving to him like a tyrant or by treating him as an equal.) (12). Authority thus requires some recognition by its subject that the person to whom the subject submits is entitled to obedience without having to procure that obedience by argument (13, 14). The obedience required by authority nonetheless remains "an obedience in which men retain their freedom" (11); one obeys authority not because one is forced to, but because one believes one has reason to (15).

This distinction of authority from power is by now a staple of Western political thought. "*Cum potestas in populo auctoritas in senatu sit*," wrote Cicero; "While power resides in the people, authority rests with the Senate" (11). Montesquieu thought of the judicial branch as the highest authority in constitutional governments, yet described its power as "somehow nil;" Mommsen referred to authority as "more than advice and less than a command, an advice which one may not safely ignore" (11). The Spartan ephors spoke with authority but were utterly powerless; their example inspired Rousseau to include in his *Social Contract* a group of wise men who could make authoritative pronouncements, but could not force compliance with them (16). Pierre Clastres has given us a striking example of separation of power from authority even outside the Western tradition: in certain South American tribes

chieftains are responsible for giving daily speeches on the tribal law but are incapable of enforcing them (17). To move to a more familiar local example, the AMA's *Code of Medical Ethics* is developed by a Council of the AMA who have abdicated their seats in the AMA's House of Delegates, and who are powerless to enforce its requirements upon rank and file physicians.

The idea of separation of authority from persuasion is also quite familiar. It is perhaps most familiar in the context of parental authority; indeed, the all-too-familiar parental response, "Because I say so!" precisely asserts a reason grounded neither on coercion nor on persuasion. Business managers set employees to tasks without having to persuade them of their usefulness. Judges — especially trial judges — often make authoritative pronouncements without backing them up with reasons.

The application of this two-fold distinction to professional practices is fairly straightforward. My physician does not need to persuade me to take my medicine; and he is not at liberty to force me to take it. He tells me to take it twice a day with meals, and I do. It is similar with my attorney's advice about how best to draft a contract. He does not bully me into accepting his draft, nor does he take the time to persuade me, clause by clause, that I ought to accept it. I accept it on his authority. To demand explanations from my physician or my attorney would thus be to challenge their authority — to imply, perhaps, that they were overreaching that authority, or to question their competence as authorities. But we are getting ahead of ourselves. Thus far we have established only that a professional's authority allows her to secure our actions or beliefs without use of coercion, and without persuasion. But in virtue of what does her authority do this? And what, if anything, makes professionals' exercise of their authority normatively legitimate? Why ought anyone to accept the bare statement of another as a reason for belief or for action?

We can find a clue to the answer in the etymology of the word. The word "authority" comes to us from two different Latin words, *auctoritas* and *auctor*. *Auctoritas*, a legal term, referred to "a surety in a transaction, the testimony of a witness, or the means for the verification of some fact, for example, a document. It apparently then came to mean the respect or dignity or weight attached to the person or document involved" (13). *Auctor* (derived from the verb *augere*, "to augment, increase, enrich, tell about"), like "author," referred either to one

who brings about the existence of something (as in "the author of the action"), or to one who "promotes the increase or prosperity of it . . . or by his efforts gives greater permanence or continuance to it" — as, for example, by writing it down or "giv[ing] an account of" it. In Roman political thought, the greatest example of an *auctor* was Romulus, founder of Rome; later "authorities" in Rome augmented or bore witness to his founding act.

*Auctor*, then, can generally be understood to refer to a founder or author, to whom a line of action can be traced back as the source; or to one who "augments" or "enriches" such a founding act; or to one who bears witness to or gives an account of such a foundation. These senses of *auctor* are, as Friedman points out, nicely summarized in the following passage from Gladstone (13):

The proper idea is that of one who adds. In strictness, this must be adding to what existed before, as a witness adds to the thing his testimony about the thing. . . . From this original form the meaning passes on to a gradual creation, the creation of something that receives successive increment. . . . An "author" comes between us and the facts or ideas, and adds to them a . . . ground of belief, in his own assurance to us respecting them. . . . And hence perhaps we obtain the largest and clearest idea of "authority," as that which comes between us and an object, and in relation to us adds something to the object which is extrinsic to it, which is apart from any examination of it by ourselves, but which forms a motive . . . for belief or action. . . .

An authority in this sense is "an intermediary between the thing he is an authority on and the persons who accept him as an authority on that thing. He has access to it and they have access to his augmentation of or testimony about that thing" (13). The authority has, for reasons of superior wisdom, experience, or knowledge, privileged access to some body of knowledge; the subjects of authority, recognizing that privileged access, agree to defer to the authority's judgment with regard to the proper interpretation of that body of knowledge in particular cases. An authority in the classical sense is thus an intermediary between his subjects and a body of knowledge to which his access is direct, theirs wholly vicarious.

Now, some contemporary theorists of biomedical ethics resent the idea that physician

professionalism is rooted in the physician's technical expertise. The physician, they protest, is more than a mere technician. But of course, the account I just gave of the exercise of the physician's professional authority is hardly an account of "mere" technical expertise. To bring a body of knowledge properly to bear on a unique, individual problem is an act of artistry.

There is a close relationship between the idea of grounding the professional morality of medical practice in the expert authority of physicians and that of grounding it in the vulnerability of the patient. To what, after all, is the patient vulnerable? Certainly to illness, but this raw fact cannot confer professional status upon the physician unless it confers such status also upon traditional healers and alternative therapists, and perhaps also upon parents, all of whom work with people who are vulnerable to illness. No, what the patient is relevantly vulnerable to is the physician's authority — that is, to its potential misuse. Of course, medicine has no monopoly on that kind of vulnerability. We are, after all, vulnerable to all kinds of authority. The misuse of other professionals' authority can land us in jail or worse. Mistaken applications of rational/legal authority can kill, or can impose great hardship. (Think about bureaucratic decisions regarding emigration or the issuance of a driver's license.) Our vulnerability to charismatic authority is notorious.

But physicians' professionalism is grounded in their expert authority because it is the nature of their authority that makes their professionalism necessary. They know something that neither their patients nor society at large can know. Both their patients and society are therefore vulnerable to professionals' misuse of their authority. Patients and society accept the professional's word as reason to believe or disbelieve, to act or to refrain from acting; if professionals are poorly trained or greedy or careless, they will believe or act wrongly, sometimes with devastating consequences. Only by their professionalism can they establish sufficient trust in the minds of their patients — and of society — to allow them to exercise their authority.

### **Physicians as Mediating Between Individuals and Society**

Our discussion of vulnerability to misuse of authority leads to the question, on whose behalf does the professional exercise authority? One standard answer is that physicians must exercise their authority in the patient's best interest.

But the Parsonian model reminds us that, as important and central to the morality of medicine as the individual encounter between doctor and patient has always been, that encounter has never been the affair of those two parties only. Healing, like illness, has always had a social side. Normally, the patient's goals and social goals are in alignment, but this is not always the case. Sometimes the physician needs to carve out some social space on the patients' behalf. And sometimes — though rarely — the physician needs to contradict the patient's wishes for the betterment of society by returning a patient to a state of mental health which he does not want; or by healing his burns even though the patient would, at the moment, rather die; or by declining to offer him any more hope.

The public trust held by professionals has not been sufficiently celebrated — or investigated. We often call attention to the special character of the physician-patient relationship, but seldom recall that every professional encounter has implications for the broader community. The actions and pronouncements of doctors often frame the social relations of their patients with their families, peers and employers. A word from a physician can trigger powerful social forces — can set in motion the social machineries of sympathy and accommodation, or stop them cold; can relieve a patient from obligation by naming his illness, or subject him to recrimination for complaining when there's "nothing wrong."

The physician's authority over the patient is thus also authority over the patient's community. He must therefore retain the trust of both, or else render his authority suspect and his expertise useless.

### **The Professional's Motivations**

Professionals, Parsons argued, are as self-interested as any other successful actors in the contemporary capitalist economy, but their interests are in status and reputation rather than in political power and wealth (5). This affords a crucial counterbalance to the professionals' right of self-regulation: for while the right of self-regulation implies that professionals could not be induced by regulators into favoring the public interest over that of their private clients, the non-pecuniary character of professionals' dominant interests helps guarantee that they could not be induced to favor private, moneyed interests over the interests of the public. Thus, professionals' non-pecuniary interests are mo-

bilized to minimize and neutralize their pecuniary interests.

There is a subtle point to be noticed here about the purpose of professional institutions (including professional customs). Professional institutions are not supposed to make physicians into saints. Parsons was adamant that professional self-regulation can work, and the interests of patients and society can be kept in balance, even if physicians are systematically and energetically self-interested. What is required is only that their self-interest be non-pecuniary in character. It is easier to turn aside short-term financial temptation if one is certain of one's high social status. The prospect of making another dollar will not distract the professional who is single-mindedly dedicated to achieving not only medical excellence, but also a reputation for medical excellence. Let the concentration on status be mistaken by laymen for overbearing pride, and the single-mindedness for narrowness. If physicians, through their professional organizations, can cultivate the proper interests — in status, in respect, in reputation for skill, in peer recognition — then their relentless competitive pursuit of these interests cannot hurt, and may even help, the rest of us.

It follows that patients and society are deeply threatened when physicians' professional institutions lose their way, and instead of attending to the issues they should be attending to — publicly articulating ethical and scientific standards, maintaining excellence in training, securing social status and recognition for physicians, fostering competition among physicians for medical publication and for public recognition, policing physicians by means of peer-review, and so on — they waste the "status-capital" of the profession by lobbying for pocket-book issues, training physicians to concentrate on money, and battling for political clout. And it is not only destructive for physicians' professional associations to concentrate on such things. It is destructive for physicians themselves to concentrate on them, even in the face of declining salaries (declining autonomy is another matter!). The authority of every physician is eroded whenever (and to the extent that) patients or the community perceive that professional opinions can be bought, either with dollars or with the promise of future political clout.

Unfortunately, a number of forces have in recent years conspired to motivate physicians to concentrate on pecuniary and political ends, rather than on professional ends. Perhaps the

most dangerous force was the entry of the government into health care as a major payer. The greatest danger of Medicare and Medicaid to the medical profession was not, as the AMA originally feared, that medicine would be "socialized." It turned out rather to be that the practice of medicine became, for perhaps two decades, extremely profitable — more profitable than ever before. This was partly because Medicare and Medicaid were relatively generous in their first years, and partly because the creation of the programs legitimated and greatly spurred the growth of private health insurance. The new profitability of medicine undermined the professionalism of physicians by encouraging them for the first time to enter, in large numbers, into health care delivery *as investors*. And it further injured their professionalism by allowing them to get used to making large incomes while paying little attention to economics (18, 19).

This cast of mind made the marketplace developments of the 1980s — the federal government's decision to extend antitrust enforcement to the medical sphere, the general rise in the intensity of medical market competition, and the advent of aggressive cost-control measures by public and private insurers alike — even more threatening to medical professionalism than they otherwise would have been. It has meant that, for the last two decades, the profession's response to the dangerous assaults on its status, its autonomy and its authority has been mixed up with its response to assaults upon its income. This has of course hurt the defense of physician professionalism politically, because it allows politicians, health-policy academics and insurers to mouth the half-truth that physicians' complaints are "only about money." But the greater damage has been internal to the profession. When physicians and their schools and their professional associations are preoccupied with struggles involving money (or the political power with which to obtain it), professionalism — and the trust in authority that it props up — is seriously threatened.

### Acts of Profession

Is it possible to shore up physician professionalism? Perhaps. There are, after all, important features of medical care that seem to dictate that it is most efficiently delivered by expert authorities (20). Surely the world would work better if patients and the community could feel comfortable trusting in those authorities,

without worrying whether the judgment of these authorities is tainted or biased by pecuniary or political interests.

How is such trust to be re-established? Only through acts of profession. What are acts of profession? The “pro-fession” of professionals is fundamentally a speaking-forth in public, before the world and before one’s fellow professionals. It is a public commitment to obeying socially accepted standards both of morality and of competence in one’s work (21). Professionalism at its core has nothing to do with the secret handshake or the private network of connections — though, in nice Parsonian paradox, the pleasure of sharing a secret gesture or the communicative efficiency of a private network can surely help secure and facilitate professionals’ commitment to their shared professional mission. Commitment to that mission is publicly announced whenever codes of ethics are published or cited or held up for admiration; whenever journal articles argue for improved medical technique or higher ethical standards; whenever obituaries or biographies or testimonial dinners celebrate the contribution of a physician to his or her field. It is also reaffirmed — as Ed Pellegrino has often reminded us — in the conversations between physicians and patients and their families (22). These are the acts of profession — the promises made by physicians to their patients and to their communities that they will use their expert authority wisely, and will not abuse it for the sake of money or power.

But how — after the 1960s’ academic skepticism about professionalism and professionals’ motives, after all the late-twentieth-century battles about HMOs and money and physician unions, after the attacks on medicine’s scientific basis, after all the failures of competence and ethicality that any patient anywhere has seen or read about — can the medical profession expect that its promises will be believed? How can patients and the public be persuaded of the trustworthiness of medical professionals?

Of course, there is no easy answer. Professionalism, like love, has only the mode of being of “possibility.” Its presence at any given moment is impossible to verify; its manifestations in conduct and language can always be explained away by reference to some ulterior motive. To prove our love to others, we can only love them. To prove their professionalism, physicians can only act as professionals, striv-

ing always to deserve the trust and admiration they hope to inspire.

### References

1. Vollmer HM, Mills DL, editors. *Professionalization*. Englewood Cliffs (NJ): Prentice-Hall; 1966.
2. Weber M. *The theory of social and economic organization*. Parsons T, editor. New York: Free Press; 1947.
3. Parsons T. Introduction. In: Weber M. *The theory of social and economic organization*. Parsons T, editor. New York: Free Press; 1947. pp. 56–77.
4. Parsons T. *The professions and social structure* (1939). In: Parsons T. *Essays in sociological theory*. New York: Free Press of Glencoe; revised ed. 1954. pp. 34–49.
5. Parsons T. *Asociologist looks at the legal profession* (1952). In: Parsons T. *Essays in sociological theory*. New York: Free Press of Glencoe; revised ed. 1954. pp. 370–385.
6. Parsons T. *Professions*. In: Sills DL, editor. *International encyclopedia of the social sciences*. Vol.12. New York: Macmillan; 1975. pp. 536–547.
7. Kant I. *The conflict of the faculties*. Gregor MJ, translator. Lincoln (NB): University of Nebraska Press; 1979.
8. Freidson E. *Profession of medicine*. New York: Dodd, Mead; 1970.
9. Starr P. *The social transformation of American medicine*. New York: Basic Books; 1982.
10. Wennberg JE, Principal investigator and editor. *The Dartmouth atlas of health care in the United States*. Chicago (IL): American Hospital Publishing; 1996.
11. Arendt H. *What is authority?* In: Arendt H. *Between past and future*. New York: Penguin Books; 1968. pp. 93, 106, 122–123.
12. Arendt H. *On violence*. In: Arendt H. *Crises of the republic*. New York: Harcourt Brace Jovanovich; 1969. p. 145.
13. Friedman RB. *On the concept of authority in political philosophy*. In: Raz J, editor. *Authority*. New York: New York University Press; 1990. pp. 74–76.
14. Peters RS. *Authority*. In: Quinton A, editor. *Political philosophy*. Oxford (UK): Oxford University Press; 1967.
15. Raz J. *The morality of freedom*. Oxford (UK): Clarendon Press; 1986.
16. Rousseau JJ. *On the social contract*. Masters RD, translator. New York: St. Martin’s Press; 1978. p. 120.
17. Clastres P. *Exchange and power*. In: *Society against the state*. New York: Zone Books; 1989. pp. 27–47.
18. Ameringer CF. *State medical boards and the politics of public protection*. Baltimore (MD): Johns Hopkins University Press; 1998.
19. Rodwin MA. *Medicine, money and morals*. New York: Oxford University Press; 1993.
20. Freidson E. *The centrality of professionalism to health care*. In: *Professionalism reborn*. Chicago (IL): University of Chicago Press; 1994. pp. 184–189.
21. Latham SR, Emanuel LL. *Who needs physicians’ professional ethics?* In: Baker R, Caplan A, Emanuel L, Latham S, editors. *The American medical ethics revolution*. Baltimore (MD): Johns Hopkins University Press; 1999. pp. 192–203.
22. Pellegrino E, Thomasma D. *A philosophical reconstruction of medical morality*. In: Pellegrino E, Thomasma D, editors. *A philosophical basis of medical practice*. Oxford (UK): Oxford University Press; 1981.