



PERSPECTIVE ARTICLE

Bioethics: What was lost what might be gained

Tom Koch, PhD

University of British Columbia,
Vancouver, BC, Canada.

Email: tomkoch@kochworks.com



PUBLISHED

31 January 2026

CITATION

Koch, T., 2026. Bioethics: What was lost what might be gained. Medical Research Archives, [online] 14(1).

<https://doi.org/10.18103/mra.v14i1.7142>

COPYRIGHT

© 2026 European Society of Medicine. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

DOI

<https://doi.org/10.18103/mra.v14i1.7142>

ISSN

2375-1924

ABSTRACT

Background: Since its inception bioethicists have advanced an ideal of medicine with both a clinical ethics and a more general organizational perspective on medicine in society. The two have been entwined from the start with, as Hastings Centre co-founded and bioethicist Daniel Callahan said, a market-based ethos

Objective: Bioethics central focus on the autonomous individual discretely able to independently make relevant decisions on health and healthcare is examined, critiqued, and reviewed from the perspective of the practitioner and as a social construct.

Methods: Bioethical literatures from the 1970s to the present were reviewed with special attention to the work of of Hastings Centre cofounder and a leading American bioethicist, Daniel Callahan. With this, attention was paid to both the social framework and the clinical perspective of both practitioner and patient.

Conclusions: Bioethics successfully sought to replace a relational practice of care and a view of the practitioner as a social critic and “guardian” in a manner that limits the service of practitioners to both patients and society. The return to a relational ethic of care would thus be the palliative better serving the patient, the practitioner, and society at large.

Keywords: Cross-border healthcare; Health governance; Collaborative governance; Health information exchange; Integrated care; European health integration; Institutional quality; Health policy.

1. Introduction

From its very beginnings in the 1970s, Bioethics has been accepted as the dominant ethical perspective on medicine, practically and in its general social outlook. It began with the declaration by Beauchamp and Childress in their landmark *Principles of Bioethics*¹ that neither the traditional Hippocratic ethic nor one grounded in religious perspectives were suitable vehicles for an ethic capable of addressing medical dilemmas in the advancing era of medicine practiced in a modern, post-industrial society.

Since its inception bioethicists have held both to a general belief in the efficacy of a principled approach and its compatibility with the neoliberal economics and their social context instantiated by Ronald Regan and Margaret Thatcher in the 1980s. With that has come a focus on the autonomous individual as the primary and in some cases sole decision maker in areas of clinical debate. Lost in this perspective has been the relational ethic of the older, Hippocratic perspective and its focus on the obligation of practitioners in relation to first, the individual-as-patient, and secondarily, to society as a whole. With that shift came a decreased sense of the practitioner's (or ethicist's) responsibility for the contexts of care, social and political, in which medicine is organized and care provided or withheld.

The advance of Bioethics as a dominant medical ethics seemed inevitable. There was no push back or critique from medical organizations or academic departments. And yet, there were other at least potentially robust ethical systems that might have served if indeed the traditional Hippocratic ethics required amendment or replacement. Unlike Bioethics these were fundamentally relational rather than individualistic in their approach. At least two, existentialism and a feminist care ethic, shared a focus on obligations rather than simply rights. These included the existentialism that began in the 1930s and matured after World War II as an activist and relational, ethic. And as Bioethics matured so too, beginning in the 1980s, did a relational, "feminist" ethics of care. Both opposed the rights-based approach for one in which obligation was the primary ethical phoneme. Implicitly, both hewed to the insistence of Simon Weil that "the notion of obligation comes before that of rights," not as an afterthought².

At a minimum any conception of morality requires some core ideal that every moral theory should in theory accept. It begins with a reasoned base while giving weight to the interests of individuals potentially affected by one's actions. Certainly, while Bioethics began with a reasoned set of principles it did so without attention to their practical applicability. It set forth an as its ideal a focus on the autonomous, individual as a consumer empowered in a commercialized market place of service. In doing so it ignored the relational nature of the clinical experience without attention to the limits of a commercialized, market-model of medical organization and care³.

The argument, here, is that in its advance, Bioethics lost a sense of the relational realities essential to clinical practice. Further, through its embrace of the marketplace as an ethical and moral model it adversely limited the role of practitioners (or ethicists) as "guardians" not only serving the needs of patients and primary but also as informed citizens capable of critiquing economic and commercial limits to medicine as a critical, social good⁴.

Methodologically, a review of alternate ethical frameworks and literatures suggests approaches Bioethics ignored. Existentialism and a feminist ethics of care present potentially alternate or at least complimentary ethical systems to the traditional Hippocratic argument. The necessity of an alternative is dictated by the failure of Bioethics as a primary ethics of medical practice and organization in a post-modern society. Its failures, from the perspective of those alternate systems, was two-fold. First was the assumption of autonomy as a primary ethical principle without attention to an argument grounded in obligations of both ethicist and practitioner to first a patient and secondarily to society. Second, Bioethics enthusiastic embrace of a marketplace ethic proscribed its effectiveness as an advocate not only for the individual in care but as well for environmental and social changes.

2. Ethics as a Contested Arena

In the 1930s a coterie of young philosophers abandoned the teachings and style of their seniors, rejecting bloodless conundrums without concrete solutions. No more careful propositions, thought experiments or erudite musings. "Why not

concentrate on the encounter with phenomena and forget the rest"⁵? Their battle cry became Husserl's, "to the things themselves!"⁶. For the new philosophers, existentialists like Simone de Beauvoir, Jean-Paul Sartre, and Maurice Merleau-Ponty, the focus became being and doing *in* the world, not an abstract, safely distanced contemplation *of* it.

Reversing that focal shift, in the 1970s another group of moral philosophers declared the Hippocratic ethics that had grounded medical practice for two millennia was no longer serviceable or sufficient⁷. Rather than a relational ethic grounded in practice they proposed a set of mid-level principles—beneficence, non-maleficence, justice, and autonomy (and respect for persons)—that might order both the practice of medicine and medicine's place in society. The assumption was that "the simple application of existing philosophical principles or concepts" was all that would be needed to answer any ethical problem arising in medicine. Practically, its ethical groundwork's practical focus was the autonomous patient as⁸ sole decision maker in a kind of medical marketplace.

Not for them the messy experiential. But then, most of Bioethics' progenitors (Beauchamp, Childress, Callahan, Thomasma⁹, etc.) lacked training in medicine, experience with the practical complexities of patient care, or a background in either economics or social policy. As Daniel Callahan later admitted, "Sometimes we felt most like the wizard [of Oz] pulling levers behind a screen and talking in a way that projected a wisdom about large moral puzzles we did not yet have"¹⁰. Those few with not only PhDs but also MDs—for example H. Tristan Englehardt, Jr.—had not practiced in years, if ever.

Today, most bioethicists remain comfortable with their role as ethical overseers of medical practice in society¹¹. They are, in the main, proud of Bioethics' performance to date and confident of its ability to address challenges emerging from ever evolving medical technologies. But those challenges are multiple, not the least a lack of consensus on the status of citizens and their right to equal care despite cognitive physical, or social differences¹².

The real problem is not new challenges or new technologies, however, but Bioethics itself. The

American response to the COVID-19 pandemic created a kind of existential reckoning "that ought to make physicians [and by extension bioethicists] rethink the fundamental ethos of [resulting] medicine, which has produced an individualistic, consumerist, science-worshipping form of medical practice"¹³.

Just as the Existentialists' reacted to the rarified discourse of their seniors' moral philosophy, so too might modern practitioners and ethicists critically respond to an emphasis on often ill-defined, principled ideals. They might focus instead, on "the things themselves". As medical ethicists existentialists, and those still embracing the Hippocratic ideal, can advance a relational, ethics of care with a central focus not on the patient as autonomous isolate in the medical marketplace but as a person in relation, in society, and in need¹⁴. An ethic thus reformed would first consider not individual rights but a set of society's interlocking obligations to the citizen and the practitioner as well as those of the practitioner to patient and to society. The result, it is argued here, would resemble and simultaneously advance the Hippocratic zeitgeist that fifty years ago bioethicists sought successfully to supplant.

3. The Hippocratic

Hippocrates ethics was grounded in a series of declarative injunctions defining the physician's duty to care in a relational exchange engaging both practitioner and patient¹⁵. Its ideals and perspective were summarized in the famous Oath through a set of injunctions and prohibitions (North 2002)¹⁶. Bioethical principles of benevolence ("Into whatsoever house I enter; I will enter to help the sick," non-maleficence ("abstain from all intentional wrong-doing and harm,") and justice were all enfolded in The Oath's injunctions. In addition, central to the Hippocratic vision but absent from Bioethics was an insistence on life as an essential, good both society and the practitioner were to protect.

For Hippocrates and his successors, the individual was perceived not as an independent isolate but rather an indivisible member of a community served by practitioners through the care of each individual person. The medicine that resulted was grounded in a reality Heidegger defined as *Dasein*, "constituted in time and place" in the world¹⁷.

Hippocrates' *Air, Water, Places* may be read today as a first text in environmental medicine and a guidebook for practitioners to promote the healthiest physical and social environments possible for all. "All reflection on what we call the body was inseparable from inquiry into places and directions, seasons and winds."¹⁸ Physicians, in this ethic, were obliged to promote the healthiest life (diet, housing, etc.) and environment for patients and the community.

4. Bioethics

Beginning in the 1970s, a group of moral philosophers without experience in medicine declared the Hippocratic ethic incapable of addressing issues arising from an evolving, modern medical science¹⁹. They offered no data in support of that indictment but instead, in the way of moral philosophers, simply declared it as a starting point for their work. The Hippocratic began with what Heidegger called "being in the world" (*In der Welt sein*) in a purposeful way²⁰. Bioethics instead declared that, "theory and principles are the starting points," moral philosophers might later somehow apply to specific questions of practice and social organization²¹.

It was never clear, however, how those principles were to be practically enacted. "To think that principlist language is self-explanatory consistently fails on many levels and across the multiple editions of Beauchamp's and Childress' *Principles of Bioethics*"²². As a critical, ordering ideal and methodology principlism, "while an elegant theoretical approach, was simply too vague to provide practical guidance in complex cases"²³. It serves best, if at all, as a kind of check-list of ideas worth considering²⁴.

Even at that level meanings were unclear, and sometimes contested. Beauchamp, for example, believed a guiding principle of "respect for persons" incorrectly conflated two distinct, independent values, respect for autonomy and avoidance of harm, or non-maleficence²⁵. While the Hippocratic ethos set life and its preservation as an ordering good resulting in practical injunctions and prohibitions (no euthanasia or abortion) Bioethics did not. Nor did it offer in its stead an applicable definition of peoples' eligible moral status²⁶. At best, a person's worth was to be defined instrumentally on the basis of their

functioning and potential contribution to an economic collective^{27,28}.

4.A. AUTONOMY

"The Oath's beginning and end situate medicine in a web of relationships between physicians and society, physicians and teachers, and physicians and patients"²⁹. By asserting "autonomy," as its guiding, operative principle, Bioethics advanced an ethic that was individualistic rather than relational. Not for the bioethicist Heidegger's "Mitzen," with each of us a being with and for others with whom we interact in the world. Autonomy as an organizing principle ignored the mutuality and moral exchange central to both the Hippocratic ethos and the existentialist perspective found in, for example, Emmanuel Levinas' *Totality and Infinity*³⁰.

While bioethicists focused upon patient rights they did so with little attention to obligations beyond a right of choice in the therapeutic encounter. But, "The notion of obligation comes before that of rights which is subordinate and relative to the former"³¹. Besides the obligations of a practitioner to a person seeking care there are, as well, those of the patient to the practitioner (respect if not necessarily obedience) and of society to provide the necessities of care physicians require if they are to provide appropriate treatment.

The Hippocratic physician's primary duty, care of the person, included a practical engagement with the social and physical conditions that bred illness and inhibited treatment in their patient populations³². After all, the ability to diagnosis and treat together "depend on social matters: practicalities, contingencies, power plays, traditions. ...they affect us all, for they involve our ways of living"³³. During the expansion of a mercantile culture and economy, officials insisted that, "The medical profession is obligated not only to treat the sick, but also to supervise the health of the population"³⁴. What was the point of caring for smallpox patients, asked eighteenth century physician Samuel Latham, if the poor were saved only to endure conditions inimical to health and guaranteed to breed another, likely fatal disease³⁵?

And, later, as nineteenth century physicians struggled with the effects of industrialization, "Local environments provided both explanation and solution for the shocking differentials in

mortality and morbidity that marked country from city, townhouse from tenement, the holds of ships or crowded military camps from farm or village³⁶. Physicians acted as activists arguing to government its duty to assure the necessities of life for all. Here was what Harvard's Nancy Krieger called "The Spirit of 1848," anchoring an obligation to public health in the actions of many in that era³⁷.

4.B. THE MARKET

Bioethics largely ignored society's duty to care, ceding control of the complex realities of patient needs and environmental realities to the marketplace, its judgment and organization. This was perhaps the most radical element of the bioethical enterprise, one grounded in what Hastings Center cofounder Daniel Callahan described as "at its heart a belief, almost religious in its intensity, that individual consumer choice and unfettered competition among providers is the key to a good health care system"³⁸.

It thus reset the patient-physician relationship as inherently commercial, one-sided, and contractual³⁹. Physician and patient became akin to seller and buyer⁴⁰. The result nicely reflected the social and economical neoliberal ethos of the neoliberal Regan-Thatcher era⁴¹. Practically, bioethicists believed that perspective essential if they were to win a favoured spot in the academy and the medicine of the day. As a former head of the American Society for Bioethics and the Humanities put it, with admirable honesty: "Ethicists have been a guest in the house of medicine, and in order to survive in that environment have had to align themselves with money and power"⁴².

In the consumerist vision of medicine and medical practice obligations to society and within the caring relationship were at best secondary. Consumers had the right of choice but not an inherent right to care or a right for the necessities of a healthy life. Indeed, there was no guarantee of a protected life for those with chronic deficits, for example minimally conscious persons⁴³. At another, structural level the market model necessarily fails as a paradigm for medical organization and service. As Nobel Prize winning economist Kenneth Arrow demonstrated as early as 1963 the elements that govern a robust economy are absent in the provision of medicine in society⁴⁴. The result has

been that marketization has resulted in higher costs and reduced availability of essential services generally, and especially in less commercially attractive contexts⁴⁵.

4.C. THE PRACTITIONER

Prior to the 1980s, health services had been generally governed by non-market values, rules and practices. In that system, "physicians were considered professionals accountable to standards and values that were different from those prevailing in typical markets"⁴⁶. It was assumed, for example, practitioners would set a patient's welfare ahead of his or her own. While bioethicists expected practitioners to continue to prioritize patient needs they simultaneously devalued their practical role and the social position of practitioners. The importance of experience and thus practitioner perspective was dismissed by bioethicists who deemed a practitioner's opinions as at best equal to if no better than those of the patients they served⁴⁷. Indeed, they were revalued by some like Robert Veatch as little more than technicians lacking any more ethical insight or moral standing than the average shoe salesperson⁴⁸.

Lost was the web of immediate obligations advanced in the earlier medical ethos between physician and patient. Ignored as well was the physician's traditional role as what Jane Jacobs defined as "guardians," those in society who might serve as a counter force to the excesses of the marketplace and the failures of officialdom⁴⁹. Society requires such guardians, Jacobs insisted, because the marketplace is neither altruistic nor beneficent; its calculus a matter of quarterly and annual balance sheets rather than the needs of the person or society at large. Markets may make economic but not necessarily healthful sense in a focus on maximizing profits and minimizing costs.

In its emphasis on commercialization, bioethicists from the start have been largely bystanders, rarely criticizing the economic and social inequalities resulting from marketization of medicine and its commercialization⁵⁰. After all, they were early supporters of the neoliberal perspectives—economic and social—of Thatcher and Regan policies. For example, Callahan declined a request by U.S. Senator Edward Kennedy the then new

Hastings Center take up the issue of a ‘right to health care’ and thus advocate for a national US health program⁵¹. He and others at the Center were not opposed but thought it would not be a cost efficient program for the then new Center. Later he reframed issues of healthcare as an issue of “cost controls” rather than social responsibility and integration⁵².

As a result, bioethics discouraged, at least implicitly, the Hippocratic tradition of practitioner advocacy and attention to the social context in which patients and other citizens either thrived or died. As Callahan acknowledged in 1993 with at best a mild regret, bioethics, “was not going to be dedicated to whistle-blowing--bioethics has not turned out many Ralph Naders, certainly not the way the environmental field has.”

Practitioners thus were caught in an essential conflict between the relational obligations of the Hippocratic ideal of care and the transactional realities of a consumerist, bureaucratic practice devaluing ethical input critiques and perspectives. “It is something of a miracle that most physicians remain faithful to their professional [Hippocratic] values in a system that does all it can to turn them into better businessmen which in fact they must be to fit into the health care system”⁵³. The unhappy result has been what in 2019 *The National Academy of Sciences* called an “epidemic of dissatisfaction” among practitioners exhausted by a sense of depersonalization in increasingly bureaucratic and commercialized practices. The realities of the recent pandemic may have exacerbated but clearly did not cause the sense of practitioner disenchantment reported⁵⁴.

5. The Failure

Accepting as given a market-base ethic insulated bioethicists from attention to systemic failures in health and health care that “persist and that, by our inaction, we condone”⁵⁵. (Barwise 2020). For decades, social scientists like Smith⁵⁶ and Wilkinson⁵⁷ have focused upon those failures and their effect on health in the healthcare systems of various countries⁵⁸. (This has begun to change with a demand by some for attention to the “moral determinants of health” and a recognition that we all “depend on each other for securing the basic circumstances of healthy lives”⁵⁹. This new

bioethical focus returns issues of clinical care to the Hippocratic perspective on medicine as relational, engaging patient and physician as well as physician and society.

Some have argued a corrective to bioethics’ current limits requires a return to a “practical ethics” artfully accepting a measure of “practical wisdom” melding science and a dollop of the virtues that presumably exist in all human relations⁶⁰. Others have clearly urged a revival of “virtue ethics” focused on the moral character, presumed good sense, and emotional responsiveness of the practitioner⁶¹. An ethics based on “practical wisdom” would require an agreement on what is both practical and “wise” (In a market economy what is ‘practical’ is primarily a matter of individual choice and service availability. But for bioethicists what is wise is grounded in the tenants of the neoliberal market economies embraced by bioethicists like Callahan, Kuczewski, et al. Virtues, after all, are social constructions more intuited than clearly defined. All this refers in the end to what might be called an “intuitive ethics” rationalizing what seems, to one or another writer, as appropriate⁶².

6. Existentialism and feminism

As bioethicists promoted their philosophy of individualism in a market society two other philosophies, existed, one mature and one developing, that might have better served the complexities of medicine in modern society. Bioethics, virtue ethics and similar approaches focused upon the individual, the patient as consumer or the ethicist him or herself. Existentialism and feminism focused instead on the person in relation, on the ties that bind and the responsibilities all have for and to each other outside a market’s limited morality.

Existentialism’s best known proponent was, perhaps, Jean-Paul Sartre, who combined a belief in individual freedom with an obligation to social engagement and activism. Tempered by the challenge of World War II, and the occupation of their countries, European existentialists argued for participation in the political lives and issues of their day⁶³. The hero in Camus’ *The Plague*, for example, was the physician Dr. Rieux who unceasingly visited and attempted to assist or at least comfort his fellow townspeople during the outbreak.

Existentialism's focus was in that and other works the person *in* relation, human association and mutual responsibility. As Merleau-Ponté put it, "We are in the world, mingled with it, compromised with it"⁶⁴. That was the starting point from which issues of care and caring were seen as an escape from the "fog of being," and the fluctuating uncertainties of personal and political life. In his 1961 *Totality and Infinity*, Levinas made the relationship of Self with Other—doctor and patient, parent and child, person and neighbor—the centerpiece of his philosophy⁶⁵. Unfortunately, existentialists never concerned themselves overmuch with the realities of interpersonal care in the arena of health and illness. What existentialism presents, here, is an alternate perspective advanced by moral philosophers that might have served, and perhaps served better, in arguing issues of medical care and its social organization.

As bioethics came to dominate, a "feminist" ethic evolved that like the existential focused not on the independent individual but personhood as an interdependent, shared reality. "The central focus of the ethics of care is on the compelling moral salience of attending to and meeting the needs of the particular others for whom we take responsibility"⁶⁶. With the existential, here was a philosophy similarly distinct from the Kantian and Hegelian, albeit with some echoes of the Aristotelian⁶⁷. Where the traditional, liberal morality focused on the individual in solitude, left to his or her own devices, a relational ethic begins with "the meeting of the needs of one person by another person, where face-to-face interaction is a crucial element of the overall activity"⁶⁸.

In feminist and existential ethics, the ideal of obligation of one to another and to others in society, precedes that of individual rights as a governing principle. In this is an emphasis on trust and mutuality result from a recognition we are all dependent and interdependent rather than isolates in the marketplace. While feminism grew from a close analysis of the relationships of family and the roles of women, the resulting, relational ethics can be 'extended to politics and society and international relations"⁶⁹.

7. Conclusion

Unfortunately, perhaps, neither existentialists nor feminist ethicists have engaged the issues of

medical ethics except, at best, in passing. They are introduced here to demonstrate the existence in moral philosophy of alternative perspectives that early bioethicists might have engaged in their desire to develop a new and more robust ethics of medicinal practice and medicine's place in the evolving, post-modern society. The embrace of a market ideology with a Kantian emphasis on the rational individual as an isolate thus was a choice and in retrospect not the best available to them. After all, the notion of morality as autonomy and self-governance without regard to the greater context was a late eighteenth century philosophical conception that reflected a growing mercantile society advancing to the first years of industrialism.

Existential philosophers were modern theorists tempered (some might say traumatized) by World War II and critics of both the method of Kantian morality and the inequities of capitalist societies. Feminism is even newer, growing out of the maternal and familial perspectives of modern women in a male dominated ethos and society. The relational perspective both present strongly echoes the Hippocratic sense of duty and obligation to the patient and more generally to society at large.

From that perspective it is clear both that bioethics was not an inevitable advance and that in its acceptance critical aspects of a social ethic and morality were lost. Gone was the sense of relation and community involving the individual, the carer, and the broader society. Lost as well was a sense of duty and responsibility for the care of persons left adrift as isolates in a medical marketplace. Bioethics did not adopt the practitioner's traditional role as guardians who might critique the effect of market excesses, bureaucratic oversights, and resulting systemic inequalities. If, as Rudolph Virchow famously said, "politics is nothing else but medicine on a large scale"⁷⁰. Then medicine is politics at a smaller scale. As eighteenth and nineteenth century practitioners knew, that meant they had need to engage in critiquing the politics of the day⁷¹.

At another level, Bioethics did not continue the traditional ideal of humanness as an essential good to be protected and preserved. Personhood as a value was left as something to be accepted or dismissed as circumstances required. Life, was no

longer an essential good. But if the central good is not the person and people but the market and its bureaucracies then health, care of the person, community, and a shared environment will always be of at best secondary importance.

Bioethics will not disappear although its role as a consultant and guide will diminish as its limits become ever more evident. A full blown Hippocratic ethic will not return, although elements of its structure may and indeed must be revalued. It is tempting to wish for the promotion of an existentialist medical ethic grounded first and foremost "in the things, themselves," in the complex necessities of care in modern societies. Certainly its relational focus can be better understood and articulated through the insights of the feminist authors advancing a distinct but complimentary ethics of care.

What is clear in the literatures of public health and economics is the extreme limits of Bioethics market embrace and its overweening, often simplistic insistence on the autonomous person. Programs in Scandinavian and other countries have demonstrated market capitalism can be tempered by an ethic of care with strongly positive health results. The result if broadly adopted would set the ethicist not as distanced arbiter but as partner and servant of patient, practitioner, and the society all together cohabit.

Conflict of Interest Statement:

The authors declare no conflicts of interest.

Funding Statement:

This research receives no funding.

Acknowledgements:

None.

Data Availability Statement

This study analyzed publicly available documents and published literature. No primary data were generated. All sources are cited in the references.

Ethics Statement

This study involved analysis of publicly available policy documents and published literature. No human subjects research was conducted. Ethics approval was not required.

Keywords:

bioethics, existentialism, feminist ethics, relational ethics.

References:

1. Beauchamp T.L. and J. F. Childress. *Principles of Bioethics*. NY: Oxford University Press; 1979, 2.
2. Weil S. *The Need for Roots: Prelude to a Declaration of duties towards Mankind*. Trans. A. F. Wills. London: Routledge & Kegan Paul, Ltd; 1949, 3.
3. Arrow K. 1963. Uncertainty and the Welfare Economics of Medical Care. *American Economic Review*. 1994; 53 (5): 941-973.
<https://assets.aeaweb.org/asset-server/files/9442.pdf>
4. Jacobs J. *Systems of Survival. A Dialog on the Moral Foundations of Commerce and Politics*. NY: Vintage Books; 1992.
5. Bakewell S. *At the Existentialist Café: Freedom, Being, and Apricot Cocktails*. NY: Other Press; 2016.
6. Bakewell S. *Ibid*.
7. Beauchamp T.L. and J. F. Childress. *Principles of Bioethics*. NY: Oxford University Press; 1979: 1.
8. Blumenthal-Barby J., Aas S. Brudney D., Et al. The Place of Philosophy in Bioethics Today. *The American Journal of Bioethics*. 2021; 22 (12): <https://doi.org/10.1080/15265161.2021.1940355>.
9. For example, Thomasma D. The Asbury Draft Policy on Ethical Use of Bioethics. *Cambridge Quarterly of Healthcare Ethics*. 1997; 8 (2): 249.
10. Callahan 2012. *In Search of the Good: A Life in Bioethics*. Cambridge, MA: MIT Press. 2012: 77.
11. Ravidsky V. *The Future of Bioethics: Challenges, Visions and Opportunities*. NY: Columbia University. Presented Online. 2024 (Sept. 28).
<https://sps.columbia.edu/events/future-bioethics-challenges-visions-and-opportunities>.
12. Jaworska A, and Tannenbaum T. The Grounds of Moral Status. In, E.N. Zalta & U. Nodelman, Eds. *The Stanford Encyclopedia of Philosophy*. 2023.
<https://plato.stanford.edu/archives/spr2023/entries/grounds-moral-status/>.
13. Elliott, C. Sisyphus Gets a Prescription. *Hedgehog Review*. 2021; 23 (3).
<https://hedgehogreview.com/issues/authenticity/articles/sisyphus-gets-a-prescription>
14. Ray K. Ending Unequal Treatment Requires a Shift from Inequitable Health Care to Social Inequities. *Hastings Bioethics Forum*. 2024 (August 13).
<https://www.thehastingscenter.org/tag/ending-unequal-treatment/>
15. Mammias I.N., Spandidos D.A. Paediatric Virology in the Hippocratic Corpus. *Experimental and Therapeutic Medicine*. 2016. 3;12(2):541-549. Doi: [10.3892/etm.2016.3420](https://doi.org/10.3892/etm.2016.3420).
16. [North M. The Hippocratic Oath. Trans. Bethesda, MD: National Institutes of Health. 2002. https://www.nlm.nih.gov/hmd/greek/greek_oath.html](https://www.nlm.nih.gov/hmd/greek/greek_oath.html).
17. [Bakewell S. At the Existentialist Café: Freedom, Being, and Apricot Cocktails. NY: Other Press. 2016: 87](https://www.otherpress.com/)
18. Kuriyama S. 1999. *The Expressiveness of the Body and the divergence of Greek and Chinese Medicine*. NY: Zone Books, 262. Quoted in, Rosenberg C. Epilogue: Airs, Waters, Places: A Status Report. *Bul. Hist. Med* 2012. 86: 661-670.
19. Beauchamp and Childress. *Op. Cit*. Note 1, 1.
20. Bakewell S. *Op. Cit*. Note 5: 63-347.
21. Beauchamp and Childress. *Op. Cit*
22. Vest M. Bioethics as a language game: probing the quality of moral guidance in principlism. *Theoretical Medicine and Bioethics*. 2025; 46 (1): 51-65. Doi: [10.1007/s11017-025-09702-9](https://doi.org/10.1007/s11017-025-09702-9).
23. Fins J. J. On the *Lingua Franca* of Clinical Ethics. *Journal of Clinical Ethics*. 2013. 24 (4): 323-31.
24. Clouser K.D., Bert B. A Critique of Principlism. *The Journal of Medicine and Philosophy*. 1990; 15:219-236.
25. Beauchamp T.L. The principles approach *The Hastings Center Report*. 1993; 23 (6): S9.
26. Jaworska and Tannenbaum. *Op. Cit*. Note 11.
27. Rothman D. Rationing Life. *New York Review of Books*. 1992 (March 5).
<https://www.nybooks.com/articles/1992/03/05/rationing-life/>.
28. Callahan D. 1990. *What Kind of Life: The Limits of Medical Progress*. NY: Simon and Schuster.
29. Stigall W. The Hippocratic Oath. *The Linacre Quarterly* 2022; 89 (3): 275-286.
30. Blackwell S. *Op. cit*. 1 98-199
31. Weil S. *The Need for Roots: Prelude to a Declaration of duties towards Mankind*. Trans. A. F. Wills. London: Routledge & Kegan Paul, Ltd; 1949, 3.
32. Krieger N. A Vision of Social Justice as the Foundation of Public Health: Commemorating 150 Years of the Spirit of 1848. *American Journal of Public Health*. 1998; 88 (11): 1603-1606.

33. Mol A. *The body multiple: ontology in medical practice*. Raleigh, NC: Duke University Press. 2022: 171.
34. George Rosen. *From Medical Police to social medicine: Essay on the history of Health Care*. NY: Science History Publications. 1974: 138.
35. Mitman G, Numbers R. L. From Miasma to Asthma: The changing Fortunes of Medical Geography in America. *History and Philosophy in the Life Sciences*. 1993; 25 (3): 391-412.
36. Rosenberg C. Epilogue: Air, Waters, Places: A Status Report. [Bulletin of the History of Medicine, 2012; 86 \(4\): 661-670.G](#)
37. Krieger N. 1998. Spirit of 1848: A network linking politics, passion, and public health. *Critical Public Health*. 1998;8 (1): 97-1003. <http://doi.org/10.1080/09581599808409215>.
38. Callahan D. Why America Accepted Bioethics. [The Hastings Center Report, 1993; 23 \(6 Suppl\): S8-9](#).
39. Reichlin M. Observations on the Epistemological Status of Bioethics. *Journal of Medicine and Philosophy*. 1994; 19 (1): 79-102.
40. Mol. *Op. Cit*. Note 32.
41. Zuckerman S, Kimsma G, and I. Devisch. Surprising pandemic experiences: A confrontation between principle-based and virtue ethics, and a plea for virtue ethics training for medical students and residents. A rudimentary outline of a four-step model. *Journal of Evaluation in Clinical Practice*. 2023; 29 (7): 11 00-1107.
42. Kuczewski M. Taking it Personally: Reflections on Living Bioethics and Medical Humanities. *ASBH Reader*. 2010 (Summer-Autumn): 3-9.
43. Fins. J. J. *Rights Come to Mind: Brain Injury, Ethics, and the Struggle for Consciousness*. NY: Cambridge University Press, 2015.
44. Arrow K. Uncertainty and the Welfare Economics of Medical Care. *American Economic Review*. 1963; 53 (5): 941-973. <https://assets.aeaweb.org/asset-server/files/9442.pdf>
45. Blumenthal D, Galfin R. The Vocabulary of Our Discontent. *JAMA*. 2025; 19 (1). Epub. Aug 18, [Doi: 10.1001/jama2025.12584](https://doi.org/10.1001/jama2025.12584).
46. *Ibid*.
47. McCullough L.B. Introduction. *Theoretical Medicine*. 1983; 4 (2): 227-229.
48. Veatch R.M. *Hippocratic, Religious, and Secular Medical Ethics*. Georgetown University Press, 2012.
49. Jacobs J. 1992. *Systems of Survival. A Dialog on the Moral Foundations of Commerce and Politics*. NY: Vintage Books, 1992.
50. Ray K. Ending Unequal Treatment Requires a Shift from Inequitable Health Care to Social Inequities. *Hastings Bioethics Forum*. 2024 (August 13). <https://www.thehastingscenter.org/tag/ending-unequal-treatment/>
51. Callahan 2012. *In Search of the Good: A Life in Bioethics*. Cambridge, MA: MIT Press. 2012: 62-63.
52. *Ibid*, 62-3.
53. *Ibid*, 184.
54. Koch T. Seeking Medicine's Moral Centre: Ethics, Bioethics, and Assistance in Dying. London: Ethics Press. 2025, 302-303.
55. Barwise A.K. 2020. Ethicists as a Force for Institutional Change and Policies to Promote Equality. *Hastings Bioethics Forum*. <https://www.thehastingscenter.org/ethicists-as-a-force-for-institutional-change-and-policies-to-promote-equality/>
56. Smith D.M. *Human Geography: A Welfare Approach*. NY: St. Martin's Press. 1977.
57. Wilkinson R. *Unhealthy Societies: The Afflictions of Inequality*. NY: Routledge. 1996.
58. Marmot M. *The Health Gap: The Challenge of an Unequal World*. NY: Bloomsbury, 2015.
59. Berwick D.M. 2020. The Moral Determinants of Health. *JAMA*. 324 (3): 225-226. Doi: 10.1001/jama.2020.11129.
60. Jotterand F, Derse A, Spellecy R. et al. Practical Wisdom, Clinical Judgments, and the Agential View. *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine*. 2025, XX: 1-12. <https://doi.org/10.1093/jmp/jhae046>
61. Zuckerman S, Kimsma G, and I. Devisch. Surprising pandemic experiences: A confrontation between principle-based and virtue ethics, and a plea for virtue ethics training for medical students and residents. A rudimentary outline of a four-step model. *Journal of Evaluation in Clinical Practice* 2023; 29 (7): 11 00-1107.
62. Haidt J., C. Joseph. 2004. Intuitive ethics: how innately prepared intuitions generate culturally variable virtues. *Daedalus* 2004; 133 (4): 55-66.
63. Blackwell S. *Op. Cit* Note 5.

⁶⁴ Blackwell S. Op. Cit. 163.

⁶⁵. Levinas E. *Totality and Infinity*. Duquesne Univ. Press. 1969.

⁶⁶. Held V. *The Ethics of Care: Personal, Political, and Global*. NY: Oxford University Press. 2006:10.

⁶⁷ Nussbaum M. Public Philosophy and International Feminism. *Ethics*. 1998;108: 762-96.

⁶⁸. Bubeck D. *Care, Gender, and Justice*. NY: Oxford Univ. 1995,121.

⁶⁹ . Held V. Chapter 10: The Ethics of Care. In Serena Olsaretti, Ed. *The Oxford Handbook of Distributive Justice*. NY: Oxford University Press, 2018: 213-234.

⁷⁰. Mackenbach J.P. Politics is nothing but medicine at a larger scale: reflections on public health's biggest idea. *Journal of Epidemiology & Community Health* 2009; 63: 181-184.

⁷¹. Koch T. Thieves of Virtue: *When Bioethics Stole Medicine*. Cambridge, MA: MIT Press. 2012: 35-36.