In the light of increasing public mistrust, there is an urgent need to clarify the moral status of the medical profession and of the relationship of the clinician to his/her patients. In addressing this question, I first establish the coherence, within moral philosophy generally, of the concept of supererogation (the doing of more than one's duty). I adopt the notion of an act of "unqualified" supererogation as one that is non-derivative good, praiseworthy, and freely undertaken for others' benefit at the risk of some cost to the agent. I then argue that committing oneself to the profession of clinical medicine is an act of this kind. This is the case, not because the aim of medicine is to help patients, but because of the open ended commitment of time and the vulnerability to the consequences of failure that the clinician must accept.
The conclusions of these and other writers, that morality, being concerned with the general good of human beings, must recognise the central importance of individual life plans and projects, largely coincide with the intuitions of everyday morality. This implies that the sphere of the morally relevant is not completely filled by the morally required. It also contains supererogatory moral actions, which are praiseworthy but not obligatory.

The concept of supererogation has been subjected to an extended treatment by Heyd, who characterises it as an attribute of acts, rather than persons or personalities. In his analysis an act is supererogatory if and only if:

- It is neither obligatory nor forbidden.
- Its omission is not wrong, and does not deserve sanction or criticism.
- It is morally good, both by virtue of its (intended) consequences and by virtue of its intrinsic value (being beyond duty).
- It is done voluntarily for the sake of someone's good, and is thus meritorious.

The first two parts of the definition are in negative terms, the second part being added to contrast these acts with permitted, non-obligatory acts whose omission would nevertheless be wrong. The third part excludes acts which have accidentally good consequences while the fourth introduces the moral agent and his intentions.

Also contained in the third part is Heyd's central thesis, that a true supererogatory act should be regarded as "unqualified" and that, is free-standing, praiseworthy, and intrinsically good in its own terms rather than derivatively. As an example of a derivative construal, RM Hare's basically utilitarian two-level theory of morality would view the concept of supererogation as a lower level moral intuition, whose existence and encouragement is justified by higher level, critical thinking, on the grounds that the overall good is served if people have that concept. Heyd rejects this in favour of a robust, positive view of supererogation as a human ideal to be admired and celebrated, perhaps to be a source of inspiration. Whether a moral theory can accommodate supererogation is a measure of the former's acceptability, and not vice versa. As the fourth part of the definition states, it is also part of the intrinsic value of supererogation that the agent acts completely freely, and with the intention of bringing about another's good. It is noteworthy also that Heyd emphasises intention rather than motive. Motives are private and often complicated, while intentions are easier to recognise.

This last point is objected to by Baron, who offers an alternative account of praiseworthiness based on Kant's concept of imperfect duties. These are duties to adopt maxims such as, for example, to act beneficently, which allow a degree of latitude in deciding whether or not to perform a particular action. The concept of supererogation, she argues, fragments the Kantian notion of duty into the obligatory and the optional, allowing agents to avoid hard acts by claiming they are supererogatory. It cannot distinguish between different degrees of praiseworthiness, and in particular, through its emphasis on acts rather than agents, it loses sight of the fact that action may be performed for reasons other than virtue in the Kantian sense of “the strength of a man's maxim in fulfilling his duty”.

This austere vision of the Kantian agent is reminiscent of Wolf's moral saint. If we withhold praiseworthiness from all agents except those who act purely from a sense of duty we are left, I believe, with too narrow a picture. Our ordinary view of praiseworthiness includes those who act from motives of enjoyment, self esteem, and even, to some extent, the esteem of others.

Onora O'Neill, contrary to Baron, argues that the notion of supererogation can only be correctly understood in the language of obligation: “it is not required but is measured by that which is required; in supererogation the ordinary measures of duty rather than the categories of duty are exceeded.”

I would add a further element, which I believe is in line with our ordinary thinking, to the concept of a supererogatory act. This is that the act should have a potential cost to the agent. By undertaking the act, the agent risks losing something which he might reasonably be regarded as being entitled to, on some scale of values that includes his own interests. This cost is the reason why what Raz calls an exclusionary permission—a permission not to perform the act despite its moral goodness—is normally applied to such acts.

I now turn to the question of whether it is coherent to apply this concept of supererogation to clinical practice.

THE DUTIES OF A PHYSICIAN

It is important to be clear about what we mean by duty or obligation in relation to medicine. Once a physician has formally adopted the profession he has acquired the duties appertaining to it. Whether or not we choose to call these duties supererogatory in relation to what we morally require of humans generally, they are not so for the physician. Privately, he may have assumed these duties at the time he decided to study medicine, or at some later time, such as when he entered a particular specialty or other role. He may well recommit himself to them many times in his professional life, or he may not have explicitly (to himself) done so at all. Publicly, however, his commitment to his professional duties derives from his having made a formal covenant to the profession, usually in the form of an oath. If there is a question of supererogation, then, it must refer to the act of covenanting to undertake the duties of the profession, since obviously there is no prior duty to make this undertaking.

It is also important to emphasise that this analysis is of an idealised picture of the physician's role and obligations, a standard to be emulated which should act as a source of inspiration. No individual fully lives up to the ideal all the time, although some approach it closely, while others fail badly. In practice, almost all physicians have, whether consciously or not, internalised a version of the ethic, and most of the time strive to approach it as closely as their limitations allow.

Several arguments have been advanced for and against the idea that to adopt a career in clinical medicine is a supererogatory act. Many of these trace the answer to the nature of the doctor-patient relationship.

There is general agreement that this relationship is a fiduciary rather than a contractual one and that medicine is thus a fiduciary occupation. The distinguishing feature here is that in a fiduciary relationship there is an asymmetry of knowledge and skill between the professional and the client (patient). The professional thus has a duty to use his skill to benefit the client, and in particular, he has a duty to override the client's requests if he believes he will not benefit the client by acceding to them. Because he knows the professional has undertaken the duty to benefit him, the client can trust him to the extent of voluntarily conceding some of his autonomy to him.

In an exchange of views in the Journal of Medical Ethics in 1986, Gillon identified this feature as the source of a special duty of beneficence owed by doctors to patients, and argued that the adoption of this special duty is “at least in part supererogatory”. While I agree that to adopt the profession is a supererogatory act, I do not agree that the duty of beneficence, at least in this narrow sense, is what makes it so. Gillon contrasts the physician with an airline pilot or butcher. The pilot’s duty is to transport passengers from a to b, but he need not be concerned with why his passengers wish to make the journey, while the butcher has no moral duty to advise his customers what and how much to buy, and he may indeed try to sell the customer unlimited amounts of goods, regardless of...
the latter's needs, without transgressing the moral rules he is expected to follow, which are simply those incumbent on everyone in society. The physician, on the other hand, is at moral liberty only to do what he has reason to believe will benefit his patient, and he may be blamed if he fails to do this. Gillon locates a discontinuity here between the duties of a doctor and those of a pilot or shopkeeper, in that the former has a special duty of beneficence. However, the pilot is similar to the physician in some ways. His passengers trust him that, within the limits of his job description, he will act in their best interests, using his expert skills, to which they have temporarily surrendered their autonomy. The doctor's job description is also limited in that, for example, he cannot be over-prompted by the amount he is to be paid, and he may incur a risk of not receiving payment. Thus the medical relationship goes beyond and is not simply a property of the job. Anyone having the necessary skills would be under the same moral obligation, he asserts, and I agree. But the point, I think, is that the physician, by freely undertaking to acquire these skills, deliberately takes on a demanding job description, which is to meet, using his skills and resources, his client's demands. The client trusts him to provide the right cut of meat, prepared correctly and safely, and not to try to cheat or poison him, while the butcher has a moral duty corresponding to this trust.

I think, with Downie, that when Gillon argues that the pilot has no special duty of beneficence because he need not question his passengers' motives in boarding the plane, he is confusing beneficence with job description. Beneficence in Gillon's sense of looking to the patient's objective interests as defined part of the job of medical care. It is necessitated by the task. For example, as an anaesthetist, part of my duty is to use my knowledge and experience to advise patients about which anaesthetic technique will be most suitable for them. It requires no more cost or effort for me to do this than it would if I gave them bad advice; to advise them correctly is simply part of my role. Other jobs have their own different, but not necessarily morally inferior, requirements and forms of beneficence. Furthermore, it is possible to do all jobs badly, and in that case the individual is blameworthy according to the very nature of the job and its consequences.

Other writers claim that the fiduciary model does not adequately fit the special nature of medicine. One argument is that since health is a primary good, without which other goods lose their value, the provision of health care should have a unique status and should not depend on ability to pay. This of course is the view that underpins the National Health Service (NHS), but Koehn would go further, suggesting that any payment to the doctor be regarded as a gratuity rather than a fee. In this model, the physician's services are not causally connected. Pellegrino's view is that, like the special duty of beneficence, open endedness is simply a property of the job. Anyone having the necessary skills would be under the same moral obligation, he asserts, and I agree. But the point, I think, is that the physician, by freely undertaking to acquire these skills, deliberately takes on the moral obligation that their possession entails. The oath at graduation, in so far as it symbolises a commitment to the ideals that medicine has imposed on itself, is what commits the physician to such a duty. I would suggest that for an individual freely to commit himself to the rigorous and open ended demands of the profession is an unqualified supererogatory act which is both beyond the requirements of duty and good in itself.

There is one other aspect of the commitment to medicine that is not generally taken into account by writers on this subject. This is the inevitability of failure and loss in medicine. It is not simply that, because of the universality of death, all medical efforts fail in the end. The very nature of human physiology and pathology contain an inbuilt radical unpredictability. No matter how skilled a physician is, he will inevitably often be wrong, and sometimes he will feel he has contributed to a patient's injury, illness or even death. In an article entitled The heart of darkness, Christensen et al describe the impact of perceived mistakes on a number of physicians. While a minority were able to shrug off their failures as being due to the limitations of medical knowledge in general, most carried an enduring burden of guilt for failing, in their own eyes, to live up to their standards. Furthermore, not only must the doctor accept this burden if he is to commit himself to the profession, he must also face the risk of public censure and humiliation at the hands of regulating bodies, courts, and the media if his performance is sufficiently unsatisfactory in their eyes. These burdens and risks are also freely adopted by the aspiring physician.

I have argued that the duties demanded of the individual physician by the standards set for the profession by itself are supererogatory and hence, in Heyd's terms, deserving of praise and respect. To the extent that the profession is not now generally held in such regard, this must be attributed to its own failure. There is an urgent need for the profession to be seen to live up to these supererogatory standards and to spell out their nature to the public, and especially to prospective entrants to the profession.

REFERENCES

Supererogation and the profession of medicine

13 See reference 12: 207.
22 Sulmasy DP. What’s so special about medicine? Theoretical Medicine 1993; 14:27–42.
24 See reference 19: 64.