Supererogation and altruism: a comment

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Supererogation can be distinguished from altruism, in that the former is located in the category of duty but exceeds the strict requirements of duty, whereas altruism belongs to a different moral category from duty. It follows that doctors do not act altruistically in their professional roles. Individual doctors may sometimes show supererogation, but supererogation is not a necessary feature of the medical profession. The aim of medicine is to act in the best interests of patients. This aim involves neither supererogation nor even the moral quality of beneficence. It is simply a job description. Morality enters medicine through the quality of the individual doctor’s work, not by the definition of that work.

When McKay argues that doctors’ duties are supererogatory he is not claiming that doctors judge themselves to be supererogatory, far less that they all live up to the ideal. His point is that the duties they agree to and internalise when they join the profession are supererogatory as compared with the duties of most other occupations. He is claiming that the entire profession in comparison with (most) others is supererogatory.

The central plank (on which Glannon and Ross also stand) is that the duties of medicine are fiduciary (stemming from the asymmetry of knowledge between the professional and the patient), and that doctors through an oath or covenant commit themselves to the open ended service which follows from this kind of duty. Since McKay leans heavily on this claim about the oath or covenant it is a little surprising that he does not cite any evidence about the content of these oaths and does not consider the possibility that not all new doctors take such oaths. Indeed, such oaths as I have read are of a general and bland nature which does not in the least suggest the supererogatory. And even if we allow that the doctor-patient relationship is fiduciary it is still true that most doctors are also in a contractual relationship with an employer to work so many sessions for a certain salary.

At this point McKay introduces one of his supporting arguments: that in medicine there is a dislocation between payment and service. Now of course that may simply not be true of some doctors working on a sessional basis. But even if it is true that in the British National Health Service (NHS) payment is fixed but commitment is open ended we do not have an argument for the supererogatory nature of medical duty. In the first place, medical salaries are very high and this is partly to reflect the open ended nature of medical duties. Secondly, many occupations, which do not claim to be supererogatory, have a similar open ended nature—for example, middle to senior positions in the civil service, or school teaching. Thirdly, even if it is true that some doctors work longer hours than those in some other jobs, is this a good and admirable state of affairs? Doctors might be more humane if they attended fewer committees, took more time off, read a few novels, and spent more time with family or friends. Personally, I’d feel a little nervous if I were attended by a supererogating hero.

A second supporting argument seems to be that physicians must take on the risk of failure with its accompanying guilt and fear of litigation. This argument splits into two: that outcomes in medicine are very uncertain despite the doctor’s best
endeavour, and that the shadow of the lawyer is at every bed-
side. The first strand worries doctors only because of their
tendency to see themselves as heroes. Indeed, it is this
tendency which has encouraged the growth of the second
strand in that it has led the public to think that every medical
failure is a case of negligence. In the present context, however,
neither of these points puts medicine as a profession into the
supererogatory category.

I should now like to comment on what seems to be the
motivation behind these articles. McKay wishes to defend the
profession in the UK context in which several unfortunate
incidents have stirred up a campaign seemingly aimed at low-
ering the status of medicine in public esteem. McKay’s method
is to remind us that at least the ideal of medicine is
supererogatory. On the other hand, Glannon and Ross wish to
counter the growing tendency in the US to depict doctors as
altruistic (which they equate with being supererogatory). This
they do by arguing that doctors perform the non-altruistic
duties of beneficence to their patients.

Now I entirely agree with McKay on the unfairness of the
current UK campaigns against doctors. But I think his
attempted method of defence (even supposing it were more
philosophically persuasive) is mistaken. One reason why the
public has so eagerly turned against doctors is that for years
the public has been subjected to doctors’ high opinions of
themselves. McKay would now have us believe that, despite the
fact that doctors have more interesting jobs than most
people, more job security, and a higher salary, they are also,
and by the very definition of the profession, morally superior.
It doesn’t take a psychologist to tell us that such a line of
argument will not improve the standing of the profession in
the eyes of the public.

Glannon and Ross begin their article by quoting from the
New England Journal of Medicine, which asserted “that medicine
is one of the few spheres of human activity in which the pur-
poses are unambiguously altruistic”7 and from the American
Board of Internal Medicine which stated that “altruism is
the essence of professionalism. The best interest of patients, not
self interest, is the rule”.8 And these quotations come from a
country in which 14% of the population have no health care at
all because they cannot afford to pay! If there is such a thing
as professional self deception it is illustrated by these
quotations. Glannon and Ross do well to counter this
smugness.

In conclusion, I should like to take up a point assumed by
Glannon and Ross, and almost universally assumed in the
corpus of medical ethics. It is that doctors (whether or not
they are supererogatory) are at least beneficent. I wish to
assert that this widespread claim is either false or trivially
true. Oddly, I have support here from Dr McKay. In taking up
this issue I am returning to an old controversy between
myself, the late Mr Paul Sieghart, and Professor Raanan
Gillon.9 My argument can be put simply. What is the basic
duty of the doctor? It is to treat patients according to their best
medical interests. This is not the moral duty of beneficence; it is
simply a job description. Or if you want to insist that it is the
moral duty of beneficence then it is one to be found in most
jobs. The “lollipop” or road crossings lady helps the children to
cross the road to school. That is her job description. Call it the
moral duty of beneficence if you like. The garage mechanic
mends your puncture. Call it beneficence if you like, but it is
just part of what he does for a living. Aristotle maintains10 that
all actions aim at some good, but he doesn’t mean a moral
good. The “good” at which all actions aim is just the point of
the action. In the case of medicine that point is the best medi-
cal interests of the patient. To pursue that aim does not put you
in the ranks of the saints and martyrs, or even of the moder-
ately morally good; it is just what you do for a living. Moral
assessment applies to how doctors do their jobs, not to the
bare fact that that is the job they do.

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