

Editorial

Medicine, profession and society

Several papers in this issue discuss from different perspectives the relation of medicine as a profession to the societies in which it is embedded. Dr Dyer looks, from an American perspective, at medical advertising and the battle in America between those who wish to continue to regard medicine as a profession and those who wish to class it as a trade. (Many British and other European doctors will be amazed to discover that the normal professional restrictions on medical advertising are themselves now prohibited under American law). Drs Grosskopf, Buckman and Garty analyse some of the ethical dilemmas manifested in the Israeli doctors' strike and hunger strike, justifying the strikes on the grounds that the public employing authorities had brought doctors' salaries down to intolerably low levels, 'far below the mean standard of the country' and lower than the salaries of nurses and radiographers.

From a British perspective Dr Brecher argues that 'unless sainthood is demanded' strikes by National Health Service workers can be justifiable – even when such strikes can be foreseen to result in preventable deaths. Dr Cannell rejects this claim, arguing that health workers and other emergency service workers voluntarily take on special – supererogatory – moral obligations which include the obligation to provide their lifesaving services on an agreed basis. Dr Cooper, in an analysis very relevant to these issues and in general to the relationship between doctors and the rest of their societies, distinguishes different senses of the word 'trust'.

At the heart of such debate is a conflict about the nature of professions. On one side are those who see professions as having at any rate a substantial moral commitment to the welfare of their clients – as groups of like-minded people sharing certain relatively arcane knowledge and skills who have what Dr Dyer calls 'an ethic of service' to their clients. Few in this camp would argue that the service of their clients is or should be the only moral objective of professionals, and few would argue that it should always take precedence over other considerations including other moral considerations. But there is no doubt in their minds that this altruistic concern for their clients and a self-imposed duty of beneficence towards them is a central and necessary feature of the concept of a profession and distinguishes professions from most other groups of

workers. In particular it distinguishes them from tradespeople who while they may behave perfectly benevolently to their customers will not – *qua* tradespeople – put their customers' interests before their own interest – which is to make a profit. Plato made the point a long time ago – 'the physician as such studies only the patient's interest, not his own' (1). While Plato and Aristotle did not claim that doctors had a special moral duty of benevolence or love of humanity towards their patients – that, according to Edelstein came from stoic sources (2) – nonetheless as physicians they necessarily had a special moral duty of beneficence – of *doing* good for their sick patients. And by the first century AD Scribonius Largus's physician 'must never neglect love of humanity and all the duties it entails' (2). The distinction is perhaps worth labelling – it is not part of the concept of 'physician' to have a love of humanity (although many doctors do have at least a basic sympathy for sick people) – but it is part of the concept of 'physician' to have a duty of helping the sick. That is why 'in the strict sense' doctor necessarily has this duty. That in no way implies – as Plato again makes perfectly clear (1) – that doctors do not have other interests, other roles, which may conflict with their medical role. It only implies that as members of the medical profession they have a moral duty of beneficence to their sick patients – a duty enunciated so clearly in the Hippocratic oath and its modern successors. Such accounts of the nature of the medical profession will be familiar to, and favoured by, its members.

There is, however, a venerable and very different interpretation of the social role and function of the professions according to which members of professions are essentially self-serving seekers of wealth, power, status and exclusivity, whose declarations of concern for their clients are mere means to their self-seeking ends. Their main concern is seen to be the accumulation of wealth. As Chaucer put it, when describing the physician in his *Canterbury Tales*, 'gold in physik is a cordial, therefore he lovede gold in special' (3). Sir Douglas Black quotes the Leveller Samuel Hartlib: 'The liberty of our commonwealth is most infringed by three sorts of men, priests, physicians, lawyers. The one deceives men in matters belonging to their souls, the other in matters belonging

to their bodies, the third in matters belonging to their estates' (4). Or as Shaw, maintaining the tradition, put it in the *Doctor's Dilemma*, 'all professions are conspiracies against the laity' (5). Vigorously opposing the medical profession's 'self image of benevolent caretaker', Ivan Illich describes the medical profession as a 'radical monopoly' which 'reinforces a morbid society in which social control of the population by the medical system turns into a principal economic activity' (6).

It would be unwise to reject out of hand either type of account of the medical profession (the second of which is most rigorously prosecuted today within the academic discipline of medical sociology). There seems little serious doubt that the profession as a whole and doctors in particular do have a genuine ethic of service to their patients. To deny this would be as blinkered as to deny that the considerable power which professional autonomy undoubtedly affords is also to some extent misused in pursuit of professional self-interest, and that there is an ever present potential conflict of the interests of patient, society and State into the middle of which doctors are sometimes, more or less unwillingly, (even in some circumstances unwittingly) plunged.

Part of the 'social contract' between the professions and society is that professions should be self-regulating. Implicit in that agreement, however, is that their self-regulation should be to the advantage of society. As soon as this appears not to be the case societies are liable to withdraw the privileges of professional autonomy and remove from the profession concerned rights to special treatment. The withdrawal of the monopoly on house purchase conveyancing from English solicitors is an example: society through its elected representatives has decided that it is no longer in its interests for house purchasing procedures to be the exclusive monopoly of solicitors. A similar process may be what underlies the battle in America described by Dr Dyer. Elements in American society clearly think that doctors' self-imposed prohibition of advertising acts against the social interest by encouraging medical overcharging. The critics hope that by legally redefining the medical profession as a trade rather than as a profession more social control against restrictive practices can be exerted, with consequent price competition leading to cheaper medical services.

Towards the other end of the spectrum, the situation which provoked the doctors' strike in Israel seems to reveal the dangers of excessive social control. Doctors having lost a considerable degree of professional autonomy as a result of State and other third party control had been, according to Garty and his

colleagues, forced into conditions of service in which hour for hour they were earning less than nurses and radiographers. How could such a situation arise, given the sociologically acknowledged power of the medical profession? Why did the profession not take action earlier to maintain its economically privileged situation? The most obvious explanation is that its professional commitment of service to its patients had previously prevented such action. Eventually, as the profession's economic status continued to deteriorate, self-interest overcame professional conscience and doctors withdrew their services in order to improve their remuneration. If this analysis is correct the Israeli experience is an important warning of the dangers to society of overdrawing on the profession's voluntarily undertaken and supererogatory obligations to its patients. If doctors are treated like any other group of workers they are likely – ultimately – to accept the same standards of obligations to their clients and to society as any other group of workers accepts. When that regrettable day comes Dr Brecher's argument (that doctors are as justified in striking as any other group) will be impeccable.

Two lessons emerge. If societies wish to preserve doctors' traditional supererogatory moral commitment to their patients they are probably wisest to continue granting doctors the special privileges and status of a profession. Conversely, the American experience seems to warn doctors against overdrawing on these professional privileges. They are granted by society in the interests of society. If society ceases to see itself as being served by granting them – either because it thinks patients' interests are not best served by them, or because they lead to excessive social costs, then the professional privileges are likely to be withdrawn. Even in a spirit of self-interest, therefore, doctors would be wise, as Dr Dyer says, to keep their ideals of service shining brightly above their more mundane concerns with status and remuneration. They will then maintain the trust – in all three of Dr Cooper's senses – which patients and society should ideally be justified in reposing in the medical profession.

References

- (1) Plato. *Republic*. Book 1:342.
- (2) Edelstein L. The professional ethics of the Greek physician. *Bulletin of the history of medicine* 1956; 30: 392–418.
- (3) Chaucer G. *The Canterbury tales* (Prologue).
- (4) Black, Sir D. *Cui bono?* *British medical journal* 1977; 2: 1109–1114.
- (5) Shaw G B. *The doctor's dilemma*.
- (6) Illich I. *Limits to medicine*. London: Marion Boyars, 1976: 43.