this group of persons as any other group which could be the object of medical interest. If it is not *in fact* possible to prevent spontaneous abortion, then it might seem that fate has absolved us of any moral responsibility. But if the causes and treatment of such abortion are *in principle* discoverable, then it seems that one has the same kind of obligation to persons at risk for spontaneous abortion as one has for any other kind of life-endangering disease.

Could one argue, because of other considerations and possible costs, that one might still legitimately let these persons die? One might, but that kind of argument would presuppose the existence of an ordinary moral obligation to be treated but that this obligation was dissolved by some other more pressing obligation. An argument that the moral permissibility of letting die would cover persons at risk for spontaneous abortion therefore would, it seems to me, be convincing only if there were evidence that nothing could *in principle* be done for these persons. It seems to follow therefore that it would be morally desirable to research the causation and treatment of spontaneous abortion not only to render the strict anti-abortion argument consistent but also to discover whether or not there would be conditions legitimately grounding practices of letting die.

Reference

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Service and the medical profession

SIR

I would like to comment on an exigent issue – the concept of 'service' as being critical to the medical profession – which was mentioned in the June issue of the journal, both in the editorial and in the article by Dr Dyer (1).

'Service' (for example, caring, compassion, listening to the patient, being interested in the patient's personal life, giving the patient sufficient time to his satisfaction and needs, and establishing a mutually trusting relationship) is more than the abstract altruism which you suggest it to be.

In fact, 'service' – in all its connotations and nuances – is a skill, one requiring time and effort, and a giving of oneself; but because of indifference it does not receive any professional recognition worth mentioning, nor does it receive any remuneration commensurate with its value; rather this service ideal which you so rightly consider essential, is considered by the public, and by many within our profession, as 'bedside manner'; as part of the physician's personality. In other words, it is taken for granted.

In the context of today's complex world of high accountability with the need to meet patients' expectations, and the highly intricate nature of medical care, the ideal of service requires much more time and effort, and places more stress on the physician than it ever has before.

Seen in this light, 'service' as a skill has expanded in complexity along with the general body of medical knowledge and medical technique; though the concept of service may not be as dramatic as a surgical technique, or an endoscopic procedure, it is every bit as important to taking care of sick people.

If we are to exhume the service ideal and restore it to its rightful place in the medical hierarchy (at the top of the list not the bottom) then two conditions will have to be fulfilled i) the 'service ideal' must be recognised as a skill, as valuable as any technical skill is and ii) the service ideal must receive proper remuneration.

If we in the medical profession do not make an effort to recognise the concept of service – some would call this 'cognitive service' – as valuable and important to the practice of medicine, then indeed medicine will have lost an important opportunity to maintain its professional status.

Reference

(1) Anonymous. Medicine, profession and society [editorial]. *Journal of medical ethics* 1985; 11: 59–60. Dyer A R. Ethics, advertising and the definition of a profession. *Journal of medical ethics* 1985; 11: 72–78.

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