SYMPOSIUM: HEROES—OR JUST DOING THEIR JOB?

Supererogation and the profession of medicine

A C McKay

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Correspondence to:
Dr Alan C McKay,
Department of Clinical Anaesthesia, Belfast City Hospital, Lisburn Road, Belfast BT9 7AB, Northern Ireland;
acmckay@totalise.co.uk

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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-derivatively 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 recent outbreak of public criticism of the medical profession in the UK over retention of organs after autopsy without consent is only the latest in a series of cases which threaten public trust in the profession. The causal factors in this unfortunate deterioration of relations are not straightforward. In many cases corporate medical arrogance has undoubtedly contributed; in some cases the deterioration has clearly arisen as a result of the irresponsible or evil behaviour of individual doctors. In yet other cases a seemingly deliberate distortion of facts and incitement of public anger by the media have played an important and arguably seminal role. We seem to have reached a point where the reaction to each new scandal feeds off the emotion caused by the last, leading into a deepening spiral of mistrust.

In the light of such events we need more urgently than ever to clarify the moral character of the clinician-patient relationship and of the profession as a group within society. Is the clinician, as has traditionally been thought, someone who sets him/herself (I will use the male pronoun for convenience) a morally higher standard of behaviour, or of life, than average, in other words a supererogatory standard, thus giving the public reason to trust him?

I will argue that to the extent that the practitioner commits himself to the practice of clinical medicine to the standard that the profession sets for itself, he espouses for the duration of his professional lifetime a moral standard that from the point of view of society in general is or should be regarded as supererogatory. This quality is of course shared by other professions, notably teaching and nursing. However, I think medicine is particularly demanding in combining a sustained, round-the-clock commitment of time and effort with the shouldering of ultimate responsibility.

I will first advance reasons for adopting the concept of supererogation and attempt to locate it in the context of general moral theory.

THE DEMANDS OF MORALITY AND THE CONCEPT OF SUPEREROGATION

Supererogation is defined as "doing more than is required by duty".[1] To some moral theorists and in some traditions this concept is incoherent. Singer,[2] writing from a strict utilitarian perspective about Third World poverty, claims that we are obliged to "work full time" for its relief; any objection that this is counterintuitive, he asserts, does not affect the argument. By not responding, we are simply failing in our moral requirements. A strict interpretation of Kant's categorical imperative, "act only on that maxim which (one) could at the same time will as a universal law",[3] might also seem to imply that, as duty is all-pervasive, the concept of exceeding it is empty. Thus Pybus[4] contends that it is part of what we mean when we say an act is morally good or praiseworthy, that we commit ourselves to universalising the judgment and saying that anyone is obliged to carry out that act in the relevant circumstances.

Objections to such uncompromisingly demanding theories are centred around the idea that morality exists to serve humanity, not vice versa. Perhaps the most telling criticism of stringent utilitarianism, which can without great difficulty be adapted to apply to other strict forms of morality, is of the kind expressed by Bernard Williams[5]; if everyone was such a utilitarian, motivated purely by the drive to improve the human condition, who would benefit from this improvement? No one would have any aims or projects of his own whose ends would be served. As Williams puts it: "Unless there were first order projects, the general utilitarian project would have nothing to work on, and would be vacuous".[6]

Other critics develop the idea that the richness of human life cannot be captured by morality alone. Susan Wolf[7] depicts an imaginary figure, the moral saint, who always speaks and acts according to the highest moral standards, and shows that such a person would lack many of the attributes that for most people are what makes life worthwhile and interesting, so that he would miss out on large areas of personal fulfilment. She concludes that the scope of morality should be limited and subsumed under a more inclusive category, which she terms the point of view of individual perfection, a standpoint that is not simply egoistic, but includes morality as that part of the perspective which relates in a particular way to the needs of others.

Samuel Scheffler,[8] on the other hand, argues that the scope of morality is potentially all-embracing, since, although most of our daily activities are not described in moral terms, the demands of morality may impinge at any time. However, his proposal of a moderately demanding morality, lying between the two extremes of egoism and selfless impartiality, contains a major role for individual self interest. Scheffler sees his view as the expression of an underlying concept of personal integration. Again, this does not represent a complacent compromise or concession to the imperfections of humanity from what would ideally be a more stringently impartial standard. Rather, it embodies an "ideal of humanity", in which the concerns of morality and prudence tend towards congruence.

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,[9] 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", 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[10] 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,[11] 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,[12] 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.[13]

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[14] 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.[15] 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[15–17] 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,[18 19] 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 overpaternalistic. The butcher has a less 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,[20] 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 is by definition 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 extent of his failure 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[21] 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 linked to the payment of the fee, he provides services regardless of the ability to pay, and he may incur a risk of not receiving payment. Thus the medical relationship goes beyond and is morally more demanding than, the fiduciary one. Sulmasy[22] reaches similar conclusions based on the argument that, because of the cost of medical education and because people freely allow medical students to use them as learning material, act as research subjects, and donate their bodies, the knowledge so gained has a special, non-proprietary quality. The physician thus does not own his knowledge and expertise but holds it in trust, and so he is morally obliged not to use it for profit, which is why payment and service should be disconnected. Pellegrino[23] agrees and goes further, asserting that the doctor's duty includes putting his health and even his life at risk, for example in the care of AIDS patients.

These arguments stretch the limits of the profession's ideal of itself. The idea of treating payment as of minimal importance probably only obtains nowadays among the admirable but marginal groups who choose to work in the Third World and among unusually deprived groups in the West. Society, collectively, has as much to gain as the students in allowing patients to be used as teaching material.

Nevertheless, there is truth in the claim that a dislocation of payment and service is a defining feature of the nature of clinical practice. I think this attribute is best seen as one aspect of a wider concept of medical obligation, which is that the physician's duties are open ended. In particular, he also cannot place a time limit on his commitment to his patient. This is in fact a more relevant aspect of his duty in the context of modern Western medicine than ability to pay, since it is part of the actual experience of most clinicians. Even with current restrictions on working hours and mutual cover arrangements, most doctors will agree that there are some ongoing responsibilities that should not be delegated. In this age, with its emphasis on leisure and self fulfilment, the physician must on occasions, which often cannot be foreseen, forgo these. He must be prepared to commit his leisure time, all of it if necessary, to the care of an ill patient, quite independently of any other considerations. This is dictated by the unpredictable nature of illness and hence the nature of medical care. The physician must be prepared voluntarily to give up what would otherwise be his legitimate self interest and his pursual of life from what Wolf calls the point of view of human perfection.

Downie[24] rejects the view that the physician's open ended commitment gives his profession a special moral status, arguing 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.[25] 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*[26] 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.

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