

## SYMPOSIUM: HEROES—OR JUST DOING THEIR JOB?

# Supererogation and altruism: a comment

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*J Med Ethics* 2002;28:75–76

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Revised version received  
28 September 2001  
Accepted for publication  
4 November 2001

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.

Dr McKay maintains that the duties of the doctor are supererogatory,<sup>1</sup> and Drs Glannon and Ross maintain that doctors are not altruistic<sup>2</sup> (although patients sometimes are). What is the difference between supererogation and altruism?

Dr McKay offers a number of accounts of supererogation, of which the most persuasive is that by Onora O'Neill: "[supererogation] 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".<sup>3</sup> Drs Glannon and Ross seem to equate supererogation with altruism (for example, in their abstract, where they say that an act of altruism is supererogatory and is "beyond obligation"). I think they are making a conceptual error here. The error arises from the ambiguity in the expression "beyond obligation", which can mean "in the category of obligation, but exceeding what strict obligation requires", or, "in a different moral category from obligation and perhaps (*pace* Kant) a morally superior one". The first interpretation of "beyond obligation" captures the meaning of "supererogation", and the second captures "altruism". For example, if you are having a very busy morning in the clinic and decide to work through your coffee break in order to minimise patient waiting times you are showing supererogation. On the other hand, if you decide to take a short coffee break and on your way to the canteen you encounter a lost visitor looking for Ward G in the south east wing and take some trouble to take them to Ward G, thus missing your break, then you are altruistic. You had no duty to act in this way but were showing kindness at some inconvenience to yourself.

If that is a correct account of the difference between supererogation and altruism then (necessarily) doctors do not act altruistically in their professional work because in their work they are acting in the category of duty. Of course, they can act altruistically in what I might term the "context" of their professional duties. For example, a general practitioner (GP) or family doctor, as a professional with public legitimacy, is entitled to sign a passport photograph as being a "true likeness". This is not exactly a professional duty, but it could be seen as altruistic (although the halo is a little tarnished in that GPs are instructed by their professional body to charge £25 for carrying out this skilled task). But, as Glannon and Ross point out, patients do act altruistically when they agree (normally without payment) to participate in tests. Granted that doctors do not act altruistically in their mainstream professional lives the question posed by McKay remains: do they act in a supererogatory fashion?

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. As far as I can understand the argument for this extreme thesis, it seems to have one central plank and a number of ancillary supports.

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 bedside. 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 lowering 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 purposes are unambiguously altruistic"<sup>4</sup> 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".<sup>5</sup> 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.<sup>6-9</sup> 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 maintains<sup>10</sup> 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 medical interests of the patient. To pursue that aim does not put you in the ranks of the saints and martyrs, or even of the moderately 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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