THE MEDICAL PROFESSION AS A MORAL COMMUNITY*

EDMUND D. PELLEGRINO, M.D.
John Carroll Professor of Medicine and Medical Humanities
Director
Center for the Advanced Study of Ethics
Georgetown University
Washington, D.C.

HISTORICALLY AND CONCEPTUALLY we have been accustomed to think of medical ethics in terms of the obligations of individual physicians to individual patients. We have largely neglected the obligations of the profession as a moral community, as a group dedicated to a common set of moral precepts. Yet much of the plight and the opportunity of our profession today rests with the way we view the practical implications of being a moral community. Indeed, some of the issues that vex us most are resolvable only through the use of our collective moral power.

This is the thesis that I want to argue this evening. I think this is a particularly appropriate topic at this time, when the Academy, as we have heard this evening, is reshaping its own mission to meet today's challenges. I would suggest that, without some clear commitment to what is required of the profession as a moral community, the full potential of the Academy's new program will not be fully realizable.

THE DILEMMA OF PROFESSIONAL ETHICS

Today, our profession faces an unenviable choice between two opposing moral orders, one based in the primacy of our ethical obligations to the sick, the other in the primacy of self-interest and the marketplace. These two orders are not fundamentally reconcilable and, like it or not, the Academy and the profession will be forced to choose between them. In that choice this Academy can play a central and indispensable role.

Should we, as some prominent medical ethicists urge, reshape our ethical codes to conform to the ethos of the marketplace, which legitimates self-interest over beneficence and makes vices out of most of our traditional virtues?[1] Or should we stand firm in the belief that being a physician imposes certain specific obligations that forbid turning ourselves primarily into entrepreneurs, businessmen, or agents of fiscal, social, or economic policy?[2]

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Frankly, I do not know how our profession will respond to this dilemma. Some physicians want to remain faithful to the primacy of the patient's welfare and the idea of a profession. Others see no reason why physicians should be held to a higher standard of ethical conduct than prevails in other professions or society. What is most distressing is the pervasive conviction in both groups that the question has already been answered, and that the ancient citadel of medical ethics has already fallen. Too many believe that it is no longer possible to be an ethical physician, and that the only choices are capitulation, accommodation, and early retirement with warnings to one's children not to enter the profession. Those who would resist feel powerless and abandoned. Justifiably, they cannot be expected to resist alone. Their burden is too heavy without the support of the whole profession. Only if we have the will to use our collective moral force will the integrity of the profession be preserved.

Medicine is at heart a moral enterprise and those who practice it are de facto members of a moral community. We can accept or repudiate that fact, but we cannot ignore it or absolve ourselves of the moral consequences of our choice. We are not a guild, business, trade union, or a political party. If the care of the sick is increasingly treated as a commodity, an investment opportunity, a bureaucrat's power trip, or a political trading chip; the profession bears part of the responsibility.

Allow me now to set out what I mean by a moral community, why I believe medicine fits that description, and what this means in the practical world of today's sociopolitical climate.

The idea of medicine as a moral community is very old. Yet for the greater part of medicine's history it remained latent or was expressed only in partial or distorted forms. Remnants of these older models remain in the consciousness of the profession even today.

Perhaps the most explicit model is found in both major parts of the Hippocratic Oath—the so-called covenant and the body of the Oath itself. The covenant follows immediately upon the invocation of the gods. It enjoins on the pupil the obligation to treat his teacher as his father, his teacher's sons as his brothers, and to teach the secrets of the art only to his own sons or those of his teacher. There is uncertainty about whether this covenant was added at a later date and about its Pythagorean provenance.[3] Whatever its source, its spirit is offensive to democratic sensibilities because it is so frankly sexist, paternalistic, and elitist. But it does impose a set of moral obligations that bind together all who share knowledge of the art, and it does introduce the body of the Oath. The explicit moral precepts shared by the Hippocratic

medical community have become the ethical ideals shared by physicians in subsequent ages and in many different cultures.

The Oath and the covenant bind physicians collectively to something other than self interest, to duties to other physicians and to individual patients. Neither the Oath nor the other books of the Hippocratic Corpus mention social obligations of broader kinds, such as responsibility for the availability, accessibility, and affordability of health care, or collective responsibility for public health, the poor, or public policy.[4] This was largely true of the stoic physicians as well, despite the cosmopolitanism of the stoic philosophy.[5]

In the Christian era the Hippocratic Oath remained intact. Significantly, the covenant was omitted, probably because the Church opposed secret societies. Christian belief placed emphasis on community and collective concern for the poor, the outcast, and the sick. Medicine itself became a vocation, a way of salvation, for physicians and patients, a moral community within the larger community of faith.

Non-Christian physicians in the ancient world and middle ages—Egyptian, Hebrew, Moslem, Indian, and Chinese—were also members of moral communities each with its own religious or quasireligious binding force. What is remarkable is the congruence of ethical precepts among physicians who held widely disparate world-views. This suggests something intrinsic to the morality of medicine as a human activity that in some way transcends culture, religion, and historical era.[6] But still, neither the Christian nor non-Christian physicians explicitly developed the idea of a moral community with definitive collective obligations to society of the kind that are of most concern today.

Until very recently, the combination of a religious perspective and a moral perspective internal to medicine united physicians in moral communities. In Anglo-American medical ethics, this tradition was fortified in the *Ethics* of Thomas Percival and the writings of the Gregorys, John and James. Percival's *Ethics* of 1803, for example, combined the central precepts of the Hippocratic Oath and Corpus, Protestant Christianity, Roman Stoicism, and the 18th Century English Gentleman.[7] Percival's ethical perspective thoroughly permeated the first American Medical Association Code of 1847 and it remains the major influence on Anglo-American medical ethics.

This gentleman doctor was a member of a privileged community to be sure, but to a greater degree perhaps than ever previously, he recognized his profession's responsibility for involvement in such socially important problems as the health of workers, the design of hospitals, care for the poor, and forensic medicine. Benjamin Rush expressed these sentiments this way, "...they entertain very limited views of medicine who suppose its object and

duties are confined exclusively to the knowledge and cure of diseases. Our science was intended to render other services to society."

However imperfect they might have been, the earlier models of the profession as a moral community implied, in nascent form at least, the idea of a collective moral identity, commitment, and obligation. In the last 25 years even these incomplete prior conceptions have suffered significant erosion under the impact of several potent social and cultural forces.

Among the most important has been the dominance in our political philosophy for 200 years of the idea of the individual as a free-standing, autonomous social unit, prior to, and indeed standing as the creator, of the community.[8] Granting the importance of individual freedom, this concept does not foster the kind of identification and commitment upon which a moral community must depend. In ethics it has tended to privatism, a focus on negative rights, and moral pluralism. The pursuit of private gain and pleasure are also given a primacy and legitimacy inconsistent with a broader social concern.

Within medicine itself many factors tend to divide physicians. Society's moral pluralism separates physicians, especially on the crucial human life issues of abortion and euthanasia. The Hippocratic ethic itself is no longer the moral binding force it used to be. Each of its precepts is being challenged so that it is hard to say what constitutes the ethics of the profession. Moreover, the current interest in medical ethics focuses on moral dilemmas in individual cases and says little about collective responsibility. Finally, the whole edifice of professional ethics is under pressure to legitimate the profit motive and to transform the physician from the patient's advocate into social engineer, entrepreneur, corporate executive, health care manager, or employee. Each new role draws the physician into a community with moral values further and further removed from primary concern for the sick person.

What collective responses we encounter are often far from morally commendable. Physicians have, for example, reacted to onerous policies by defending their prerogatives or remuneration instead of objecting to how such restrictions compromise good patient care. Some physicians take an aggressively retaliative stance, urging physician sponsored corporations, unions or strikes. Others retaliate in less overt ways—refusing to see poor, Medicare, Medicaid, or AIDS patients. Clearly, the possibility of collective action is seen in terms of a guild and this is antithetical to a true moral community.

This deterioration of medicine as a moral community has had serious consequences for the profession and society. As a result, no collective voice speaks for the patient, resisting policies and practices that undermine ethics or endanger patient welfare. Physicians are retrenching into a kind of self-

protective moral atomism that puts personal survival ahead of moral purpose. No leadership is provided to advocate the care of the sick as a primary concern or to stand for the just distribution of health care or to counter the dominance of the market ethos. When physicians speak there is sometimes little to indicate that they are acting in anything other than their own interests. Those who do resist are often isolated, abandoned, or ridiculed by their colleagues. The enormous moral power latent in the community of medicine is ignored or repudiated. This refusal to act as a moral community is self-defeating. It robs the profession of its most credible and effective means to neutralize the hostile forces besieging it today.

THE IDEA OF MORAL COMMUNITY

A moral community is one whose members are bound to each other by a set of commonly held ethical commitments and whose purpose is something other than mere self-interest. This moral purpose may, as in the case of medicine, arise in the nature of the activity in which the members of the community engage, or, as in the case of churches or philanthropic associations, it may arise from commitments freely chosen by its members. Individual members are bound to support the moral aims of the community to which they belong. Not to do so is to dissociate oneself from that community and to betray the covenant of commitments that gave birth to the community in the first place.

It is important to distinguish between mere commitment to common beliefs and a truly moral community. Groups can be united behind morally erroneous or reprehensible commitments. Simply asserting a set of commitments, therefore, does not make a community morally good. White supremacists are united around a totally indefensible moral belief, as were the Nazi physicians. I have already alluded to some of the self protective retaliatory attitudes that unite some physicians. These would not constitute the basis of a morally good community. A morally good community is one whose common commitments are grounded in something other than self-interest and meet criteria of moral validity.

Defined in this way, a moral community means several things: First, its members share a covenantal relationship with each other and with society. That covenant is the promise, singly and collectively, to foster certain ethical ideas and standards. Second, the moral community has itself a certain life independent of who its leaders or members might be at a particular time. The ethical ideals of medicine have outlived bad doctors, self-serving medical guilds, and bureaucratic institutions. Third, a community is something more

than the simple addition of its individual members: "Whenever men act in concert for a common purpose, they tend to create a body which...differs from the individuals of whom it is constituted."[9] That body has a power for good and harm that none of its individual members alone could marshal. A moral community would by definition have to use its power for good. A moral community is therefore one which can be trusted to stand against the values of the society in which it resides if that society's values frustrate the moral purposes to which the moral community is dedicated.

The ethical basis for the idea of a moral community and the ways collective responsibility can or should be exercised are subjects of current philosophical interest. Their theoretical foundations are yet to be firmly established. But I believe medicine affords one of the more concrete and specific examples of those traits that would characterize moral communities.[10,11]

MEDICINE AS A MORAL COMMUNITY

Medicine qualifies as a de facto moral community not simply because its members are dedicated to a common purpose and a common set of ethical ideals but because those ideals are morally grounded. This involves something more fundamental than the arbitrary commitments of physicians. Four aspects of medicine as a special kind of human activity give a moral status to its individual members and to the collectivity that we call the profession: the inequality of the medical relationship, the nature of medical decisions, the nature of medical knowledge, and the ineradicable moral complicity of the physician in whatever happens to his patient.

VULNERABILITY AND INEQUALITY

A central phenomenon of illness is the vulnerability of the sick person and the consequent inequality it introduces into the medical relationship. Even the most self-sufficient person becomes anxious, fearful, and dependent when illness occurs. Patients lose freedom to pursue life's goals, to make their own decisions, and to heal themselves without access to specialized knowledge and skill. Pursuit of relief, cure, and return to health become central preoccupations. In this state the sick person is forced to consult another person who holds the needed knowledge and skill and who therefore has power over the ill person.

These facts impose a condition of inequality on the medical relationship paralleled by few other situations in democratic societies. Taken together they add up to a state of unusual vulnerability. This inescapable vulnerability imposes de facto moral obligations on the physician. In a relationship of such

inequality the weight of obligations is on the one with the power. This is very different from the ethos of business where vulnerability is an opportunity to exploit one's adversary. On the contrary, the physician has the obligation to protect the patient's vulnerability against exploitation. He is obliged to be faithful to the trust that is ineradicable in medical relationships. When he offers to help, the physician elicits trust that he will act for the good of the patient, not his own good, the good of society, science, the family, or any other entity.

THE NATURE OF MEDICAL DECISIONS

The second thing that makes the medical relationship a moral enterprise is that the most serious medical decisions combine technical and moral components. The physician must be scientifically correct in his diagnosis and choice of therapy but, at the same time, his recommendation must be for the patient's good. The later includes more than the patient's medical good.[12] The patient's moral right of self determination must be respected. The physician must assess the moral status of what he offers to do. He must decide whether his own moral beliefs are consistent with what the patient requests. There are moral issues, of course, in all human relationships, but because of the special vulnerability and exploitability of the sick person they assume overriding importance in medical relationships. The good of the patient is the end and purpose of that relationship. But this is as much a moral as a technical good. To see the relationship of technical and moral aspects of medical decisions and to place them in the right order is itself a moral obligation.

THE CHARACTERISTICS OF MEDICAL KNOWLEDGE

Medical knowledge has certain characteristics that generate obligations in those who possess it. For one thing it is practical knowledge, knowledge intended for a specific purpose—the care of the sick. It is not knowledge to be acquired primarily for its own sake. In addition, medical knowledge is obtained only through the socially sanctioned privilege of a medical education. Society permits the invasions of the privacy of sick persons that medical education demands. Students are allowed to dissect human bodies, see autopsies, engage in experimentation, practice their skills, and gain experience in clinical care. These privileges cannot be bought for a price, like other commodities. No tuition could generate a right to the invasions of privacy required in medical education. Further financial subsidization is provided by society to assure an uninterrupted supply of medical personnel, not primarily to provide students a future livelihood.

We must not forget that physicians are granted a monopoly over medical knowledge. They are allowed freedom to accredit educational programs and to set standards of practice, to admit and to eject from the medical community. This creates in the profession a reciprocal collective responsibility to assure that medical knowledge is available, accessible, and accurate. The physician's knowledge can never be his private property because medical knowledge is entrusted to the profession for the care of the sick. Physicians are its stewards, not its exploiters. As stewards we are obliged to preserve, validate, teach, and extend medical knowledge and to see that it is available and accessible to those for whom it is acquired in the first place.

These three facts about the medical relationship—the vulnerability of patients, the moral nature of medical decisions, and the stewardship of medical knowledge are common to all who profess medicine. It binds them de facto and imposes moral obligations on all who belong to the medical community. Physicians enter an implicit covenant when they accept the privilege of a medical education and the stewardship of medical knowledge that covenant entails. They make that covenant explicit by the Oath physicians take at graduation. This oath is a public promise that those who swear it can be trusted to possess medical knowledge and to use it in the interests of the sick. Significantly, it is the Oath that signals entry into the profession—not the degree or the license to practice. Most medical associations repeat this same promise in some form or another in their official pronouncements.

MORAL COMPLICITY

The physician by virtue of his covenant and the way medicine is practiced is the final common pathway for whatever happens to his patient. No order can be carried out, no policy observed, and no regulation imposed without his assent. He it is who writes the orders that other health professionals carry out. He is inescapably the final safeguard of the patient's well being. The physician is therefore de facto a moral accomplice in whatever is done that adversely affects his patient. The physician cannot be a double agent—either he serves primarily the patient or primarily the hospital, the economic or fiscal policy, or the law. When they are in conflict, he is the one who acts for or against the patient's well being. This ultimate responsibility is not transferable to others. Without the cooperation of physicians the Nazi homicides would not have been possible.[13] Nor the exploitation of the sick for profit.

THE MORAL COMMUNITY IN PRACTICE

These four facts about the medical relationship make it a moral enterprise in which each physician is a moral agent with specific role-related duties.

While each physician is therefore individually accountable, no physician alone can be expected to fulfill the whole spectrum of obligations that belong to the whole moral community. Indeed, without the collective moral support of the entire profession, few individual physicians could fulfill their individual obligations in the practical world. The moral power of the whole medical community is essential.

I do not wish to ignore that in many ways the profession, through its national state, or local societies and hospital staffs, has manifested sensitivity to the idea of a moral community. We can cite as a few examples affirmation of the moral obligation to treat patients with HIV infection, conscientious fulfillment of peer review responsibilities, updating of ethical codes and guidelines, dissemination of education in preventive medicine, notably with respect to smoking, fatty diets, exercise, use of drugs, alcohol, safe driving, boxing injuries, care for the poor and the homeless, establishing standards of medical education, etc.

These are all commendable evidences of professional responsibility. But they do not address the more sensitive issue of professional self interest and the advocacy role the professional should play in the conflict between an ethic based on the market ethos and one based in the moral nature of the medical relationship. Without in any way depreciating what is being done by many conscientious individual physicians and their organizations, I suggest that the full spectrum of our obligations as a moral community is yet to be fulfilled. We have yet to use the tremendous moral power we have for good. To do so we must act collectively in certain ways.

We must begin by examining ourselves and admitting that all of the fault for the parlous state of medical care today does not lie outside the profession. To be sure, our *bêtes noîres* are not imaginary—the malpractice crisis, inimical public and regulative policies, insurance carrier venality, corporations ducking responsibility for health care, the ethos of the marketplace replete with its advertising, competition, bottom-line-fixated administrators, for-profit hospitals, meaningless paperwork, etc. The list is long and distressing. The tendency to blame our moral desuetude on the "climate" of medical practice is understandable and in part justifiable. But we must also realize that self-righteous complaints are self serving. They severely compromise our moral integrity. We can restore it only by taking the moral high ground, by acting not on the basis of what external forces do to us, but on what they do to those we serve.

Some of the evils inflicted on the body of the profession are self-generated. Some physicians have refused to see Medicare and Medicaid patients, refused to treat HIV infection, or to go to the emergency room, and even go on

strike. Some physicians have defrauded the Medicare/Medicaid system or insurance carriers. Some physicians have charged unconscionable fees, been unavailable, or overly protective of their colleagues in the fact of incompetence or venality. I emphasize *some* physicians. Most have not done these things but all must recognize that the current climate is not simply the result of a massive conspiracy against the profession. If we are a moral community we are all touched by the virtues and vices of our confreres. We must feel demeaned by them and act to repudiate them.

We must take a stand against the evils inside and outside of medicine on one ground only—the damage and danger they pose for the sick. Every one of the things that disturb the conscientious physician—in his colleagues or in today's social milieu—can be effectively opposed if we are faithful to the central aim of medicine: the care and cure of the sick. Were we to take this position we would have public sentiment with us. We must demonstrate that our first concern is not our own privilege, prerogative, or income but the welfare of those we have a covenant to serve. There is enormous moral power in this position but we have not used it.

But our advocacy will be an empty gesture or interpreted as another public relations gimmick if it is not accompanied by actions. It is not my purpose this evening to write a moral agenda for the whole profession, but there are a variety of efforts organized medicine—or new associations of physicians—can undertake to make the professions' advocacy role authentic and effective.

We should collect the data needed to convince the public and legislators that the free market, commercialization, and monetarization of medicine is unjust and damaging to the welfare of the sick. Anecdotal accounts are not sufficient to make the case, impressive as they may be. If there is clear evidence that a given policy is injurious to patients we must resist and even refuse to carry it out. No policy can make all of America's physicians do what they think is morally wrong. To comply is to be an accomplice in a violation of our covenant with the sick patient.

We should resist the uncritical acceptance of the idea that rationing of health care is necessary in America. Even a superficial comparison of the magnitude of health expenditures with the ways we spend billions of dollars in discretionary income should convince us that needed medical care need not be withheld. Before physicians talk about rationing they can take steps to reduce the waste of resources in unnecessary and duplicated work-ups, procedures, operations, and medications. We can fight to reduce the administrative overhead (perhaps 15–30% in the opinion of some economists) imposed on health care expenditures by "managed health care systems" with their administrative bureaucracies, advertising, and marketing budgets.

The profession can initiate and cooperate in efforts to eliminate excessive fees by adopting a fee schedule and a relative value scale system of compensation. Personal financial investment in health care facilities should be ethically unacceptable. Physicians by virtue of their heavy responsibilities are entitled to just compensation, but they must not regard themselves as entrepreneurs with a monopoly and a franchise to exploit medical knowledge. We should heed the plea of the editor of the *Journal of the American Medical Association* and others for a return to the tradition of pro bono work for the poor as part of the responsibility of every physician.[14]

What America, the sick among us and the health care system, need desperately is moral leadership and medical statesmanship. That leadership cannot be achieved by individual physicians acting alone. But acting as a moral community the profession has enormous power to resist the forces it finds so inimical to the well being of its patients and its own well being through that power. We can influence the public, government and industry to re-evaluate their values, and to appreciate that the fulfillment of each person's potential is impossible without health and medical care for all citizens.

Medicine cannot and should not undertake all of this alone. We must join with other concerned people and legislators. We do not need more reports from Commissions, panels, and committees on how to solve the health care "crisis" by another prescription for tinkering with the mechanisms. The answer is clear—America can have health care of quality for all if we order our priorities as a nation, if health professionals dedicate themselves to the care of the sick primarily and not to self interest, if professional organizations fulfill their moral responsibilities to the public, and if America decides that it wants to be a caring rather than an acquisitive society.

I hope that my arguments for medicine as a moral community with collective responsibilities have some appeal to this Academy at this time, when it initiates its new program. I certainly do not suggest that the Academy follow my agenda. But I hope that it will devise its own way of acting as a moral community—for that is what the Academy cannot escape being. In saying this I am repeating only what one of the Academy's most distinguished presidents, Abraham Jacobi, in his inaugural address in 1885 listed as a major purpose of the Academy: "The advancement of the character and honor of the profession."[15]

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