# Guest Editorial

# The Family of Medicine, Broken or Extended? The Need for Moral Cement

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The concept of medicine as a family first appears in the preamble to the Hippocratic Oath; the author speaks of the father-son relationship of teacher and student and of their obligations to each other as members of the family of medicine.[1] Introduced in a moral and ethical document, and acting as a unifying force that made strangers into brothers, fathers, and sons, the notion of medicine as a family was a moral commitment, a dedication to the common set of moral values contained in the Hippocratic Oath. Today, it is timely to ask some vexing questions: To what extent is medicine a family at all? Are there bonds of affinity and dedication beyond self-interest that warrant calling us a family, or are we suffering the same divisive tendencies that afflict the nuclear family? If we are, indeed, a family, what kind of family are we?

It is important to realize that the Hippocratic Oath, and the familial tie that went with it, did not include all Greek physicians—only those who, as Edelstein shows, shared the Pythagorean philosophy.[2] Thus, at its beginnings, the family of medicine was a divided family. The Hippocratic tradition was a moral one. Those who embraced it became members of one family. The moral force of that tradition gradually included the majority of physicians in the West, but it took many more centuries and the further moral reinforcement of the major religions before the majority of physicians became members of the same family of medicine. Similar traditions built on Chinese and Indian moral systems united physicians outside the West.

In the West, the family of medicine persisted only so long as a consensus on its moral commitments persisted. In 20th-century America, the roots of that moral consensus, predominantly religious, became loosened. Most of the prescriptions of the Hippocratic Oath are questioned today. Some are overtly denied. The moral bonds that united all physicians are much weakened. One needs only observe the severe reductions in the number of code commitments in successive American Medical Association codes.* The question today is whether there remains enough common moral commitment even to speak of a family except in the sociological or taxonomic sense, ie, considering physicians only as a species of social functionary.

Nuclear and extended families fragment when their members no longer accept the common ideals, or revolt against them. This fragmentation was the most disturbing element in the youth re-

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*The first American Medical Association code contained approximately 5,200 words. The latest version contains approximately 250. I would not want to argue that prolixity is a moral virtue. The earlier code contained much that was not strictly ethics, but it did make commitments to levels of service that one does not find explicit in the recent trimmed-down version.[3]

volt of the 1960s. The family of medicine faces a similar dissolution today. The moral and ethical foundations that formerly undergirded the medical profession are everywhere being questioned. No longer can it be assumed that the good of patients is a transcending obligation for all physicians.

Western society is experiencing a time of moral heterogeneity and moral relativism in which people differ in their most fundamental philosophical and religious values. This diversity permeates medical ethics and even the concept of what medicine is about. Physicians are acrimoniously divided on such human life issues as abortion, sterilization, whom to treat, whom to let die, how to allocate resources, and how to balance social, economic, and fiscal responsibilities against traditional responsibilities to individual patients. Medicine is a pluralistic profession in a pluralistic society, no longer the family envisioned in the preamble to the Hippocratic Oath.

John Gardner said this about pluralism: "A society in which pluralism is not undergirded by some shared values and held together by some measure of mutual trust simply cannot survive. Pluralism that reflects no commitments whatever to the common good is pluralism gone berserk."[4] I have not the prophetic discernment needed to say whether our pluralism has gone berserk. Nor am I presumptuous enough to think that I can define our common goals in a way that would gain wide consensus. I can, however, pose the fundamental questions we must ask ourselves if we are to regain any sense of familial unity as a profession.

To regain unity, a set of commitments must be sought that, even in the presence of moral pluralism, will define medicine as a profession and a medical family. Those commitments are best grounded in two things: the nature and purpose of the physician-patient relationship and the definition of the profession in the face of that relationship. This relationship, common to all the specialties, is a reality that transcends advances in medical technology, politics, and economics; it will survive as long as people become sick and others offer to help and heal them.

Physicians are far from agreement on the nature of their relationship with patients. Look for a moment at the major opposing models. Each leads to a different kind of ethical commitment. Each has strong and dedicated proponents. Each constitutes a different family of medicine.

## Medicine as Applied Biology

The physician can be viewed primarily as a scientist, a highly skilled technician whose only ethical imperative is competence and who equates the whole of the good of the patient with what is medically indicated. With this model the patient's and family's values are secondary to medical indications. Any choice other than the physician's is irrational. Indeed, since the patient cannot comprehend scientific fact, he is ipso facto incompetent to make a choice. With this model, the ethics of medicine are reducible to the ethics of good science. Human values and ethics are not denied, but are outside the province of medicine.

## Medical Care as a Commodity Transaction

Medical care can be likened to the sale and purchase of a service—a means of livelihood for the physician not different in any way from the purchase or repair of an automobile. With this model the ethics of medicine are reduced to the ethics of a contract or to business ethics. This view generates a minimalist and legalist concept of ethics ruled by the exigencies of the marketplace, price competition, and market dominance. Medical knowledge becomes proprietary knowledge owned by the physician and sold on his terms. Investment in the health care industry and medical entrepreneurship are encouraged along with advertising and corporate and for-profit medicine. Medicine thus becomes, as Ginzberg has put it, "monetarized"—subjected to the rules of money management.[5]

## Practice of Medicine as a Helping and Healing Activity

Illness and its effect on the functioning of human beings can make medicine essentially different from a scientific problem or a business transaction. In the model of the physician as helper and healer, the patient is viewed as an afflicted being. Illness, as an assault on his very humanity, makes him vulnerable, anxious, dependent, exploitable, less free to pursue his life's goals, and in need of help. The sick person deserves all the dignity and has the human value of

the well person, yet he is in a position of inequality in which the operation of his humanity is compromised. The ethics of the helping and healing model are based in the obligations illness imposes on those who have the knowledge and power to heal and help. Medical knowledge is not proprietary. It is a common possession of all humanity. The ethics of the helper model are very different from the ethics of medicine as science or business. They place the good of the patient and the patient's value above scientific and economic values, above the self-interest and profit of the physician, demanding self-effacement and a guarantee that the patient's vulnerability will not be exploited for prestige, power, or profit. The physician's act of profession, therefore, becomes a promise of help and healing, a covenant of service.[6]

Each of these three models—scientific, commercial, covenantal—has enthusiastic proponents today. It is difficult to know which will predominate. I do know, however, that the kind of family that medicine becomes and the ethical obligations it assumes will depend on the choice physicians make among these models.

That there is obviously much science and some business in medicine is not in dispute. The issue is which shall be the primary commitment and which shall be the ordering principle when scientific, business, and covenantal values come into conflict. Each physician must decide which family he wants to join, and the public has a right to a clear declaration of a physician's commitment. If physicians are to be committed primarily to business, they should say so and not delude themselves or the public into thinking anything else. If physicians aspire to moral commitments that transcend those of business or science, then they must make those commitments publicly and live up to them.

Paradoxically, the differences in the answers to these questions will themselves unavoidably be divisive. The answers will at least, however, either make physicians conscious members of one family or establish a decision against such membership. In either case, the delusion and the hypocrisy of professing to be members of a family without genuinely espousing its values will be avoided.

Closely allied to the conception of the relationship of patients and physicians is the conception of what it means to belong to a profession. No idea has been more debased than the concept of profession. Today, anyone who undertakes any activity full time, for pay, or with high skill, anyone with special competence or knowledge, anyone with a college degree or credential, anyone who performs some needed service can claim to be a "professional." The list ranges from athletics to astrophysics, from carpentry to selling automobiles, from medicine to mortuary science, from pipe-fitting to politics. Whoever is not an admitted amateur, a dilettante, a hobbyist, or an apprentice is automatically accorded the title of "professional."

I have no quarrel with the recognition of anyone who pursues excellence in performance. Nor do I wish to preserve the term *professional* for some elite purpose. In any case, true elitism is not born of titles, but of the voluntary self-imposition of higher than ordinary standards.

Nonetheless, do not forget physicians have made a public act of profession, a declaration that they are healers and helpers of the sick. They have promised that they will not place their own interests first, that they will not exploit the vulnerability of those they serve, that they will honor the trust illness forces on those who are ill. It is this inherent necessity for a higher standard that impelled Plato to use medicine as his paradigm of the ethical use of knowledge. Medicine for him was a *teknē*, a craft and art to be sure, but a craft with a very significant difference from all the others.

In the first century AD, when the concept of *profession* was first used, it was tied to a special promise of compassion. Indeed, compassion was so clearly tied to being a physician that it was a moral obligation.[7] When medicine lacks this ethical dimension, it does not merely descend to the level of a business, trade, or technique; it betrays a trust, and it demeans both physician and patient. It is this betrayal that leads to angry and satirical attacks on physicians. Although pomposity, callousness, and cupidity are common human failings, they elicit special rancor when exhibited by physicians because even their severest critics expect better of them.

Physicians' abuse of the trust demanded by the nature of their duties invites corrosion of the profession of medicine. Physicians must merit the trust their act of profession demands. If they do not rise to professional obligations, they can hardly protest when they are satirized and their profession is treated as a trade or business, to be regu-

lated as such by the Federal Trade Commission (FTC). Moral credibility is the physician's to establish or to lose; it is inappropriate to blame its loss on the FTC, Congress, the media, or the general moral standards of society.

The nature of the acts physicians are expected to perform, together with the trust those acts demand, forms the basis of a professional morality, binding health professionals even when their philosophical and theological principles may differ widely. Only physicians themselves can determine whether a promise to help the sick is a solemn promise, a contract, a commodity transaction, or a business ploy. How physicians define their act of profession tells more about them than any rhetoric or codes of ethics.

Moral choices are more difficult, more subtle, and more controversial now than at any other time in medical history. A commitment must be made without the heritage of shared values that could unify medical ethics in previous times. The task is not to abandon hope in medical ethics, but to undertake what Camus called "the most difficult task of all, to reconsider everything from the ground up, so as to shape a living society inside a dying society."[8]

I believe the medical community is returning full circle to the diversity that obtained within Greece at the time the Hippocratic Oath was composed. Then, as now, medicine had a divided family—with its members defined and differentiated on the basis of their moral commitments. Now, as then, some will adhere to a code based on helping, healing, and self-effacement, some will make a primary commitment to technical and scientific competence, and some will adopt the values of business, economics, and their own self-interests.

These commitments necessarily overlap, since medicine comprises science, business, and healing. However, it is the model accepted as an organizing principle that defines the family of medicine to which a physician belongs. In due course the public served will perceive the differences and will accord the title *physician* only to those whose moral commitment transcends self-interest, the application of technology, and the pursuit of business.

I see, too, the real possibility of a true extended family, embracing all health professions, committed to healing and helping and willing to make the commitment to higher standards of moral behavior. Nurses, dentists, pharmacists, allied health workers, administrators—all who will commit themselves to the good of the patient as a primary obligation—will become by moral commitment, not sociological classification, members of the family of healers. They can and will share an ethical code that emphasizes a common commitment to healing and helping with all the resources of modern times.[8]

The future of the family of medicine depends, therefore, on a renewal of its moral goals and values and a restoration of the binding and bonding forces that first gave it birth. That renewal will be selective because physicians will make different commitments. The task of leaders will be, as John Gardner defines it, ". . . to conceive and articulate goals in ways that will lift people out of their petty preoccupations and unite them toward higher goals. Leaders have a role in creating the state of mind that is the society—knowing what we can be at our best."[4]

Family medicine, if it is to be true to its commitment to integral medicine and to its concern for healing the human person scientifically yet compassionately, can only choose the covenantal model. Family medicine, authentically practiced and taught, can lead to the reformation of the family of medicine—nuclear and extended.

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