INTEGRATING MEDICAL ETHICS WITH NORMATIVE THEORY: PATIENT ADVOCACY AND SOCIAL RESPONSIBILITY

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ABSTRACT. It is often assumed that the chief responsibility medical professionals bear is patient care and advocacy. The meeting of other duties, such as ensuring a more just distribution of medical resources and promoting the public good, is not considered a legitimate basis for curtailing or slackening beneficial patient services. It is argued that this assumption is often made without sufficient attention to foundational principles of professional ethics; that once core principles are laid bare this assumption is revealed as largely unwarranted; and, finally, that these observations at the level of moral theory should be reflected, in various ways, in medical practice. Specifically, this essay clarifies a tension that exists between different kinds of moral principles and explores the possibility of dissipating that tension by shoring up foundational principles. The paper begins by setting out three alternative models of how best to balance patient advocacy responsibilities with broader social responsibilities. It then turns to critically assess these models and argue that one has several advantages over the others.

Key words: ethics professional, health care rationing, patient advocacy, physician's role, social justice, social responsibility

INTRODUCTION

No matter how much physicians strive to avoid ethical conflict, their professional lives seem at times to preordain it. This fact is mirrored at the level of ethical theory, where philosophers confront principles that often look, at first glance, to be muddled and disjointed. A common form such conflict takes is that physicians are expected, by virtue of their role as physicians, to put the health and welfare of their patients above all else.[1] At the same time, as functionaries in institutions held to standards of justice, physicians are instructed to do their part to realize justice and the public good in institutions they serve. Although this conflict is often felt vividly among physicians themselves, the important aspect of it with which I will deal is its presence at the level of moral theory. Specifically, this essay clarifies a tension that exists between different kinds of moral principles and explores the possibility of dissipating that tension by shoring up foundational principles. The paper begins by setting out three alternative models of how best to balance patient advocacy responsibilities with

Theoretical Medicine **11:** 125–139, 1990.

broader social responsibilities. It then turns to critically assess these models and argue that one has several advantages over the others.

THREE MODELS OF PATIENT ADVOCACY

Let me begin by culling from recent literature some alternative depictions of the proper balance between patient advocacy and social responsibility. The following characterizations are among the most prominent.

1. Unrestricted advocacy: considerations of justice either provide no moral basis for individual actions or provide a basis relevant only after primary, role-based duties are fully discharged.

2. Minimally restricted advocacy: considerations of justice do furnish a moral basis for individual action, because principles of professional ethics derive from roles specified by just institutions.

3. Maximally restricted advocacy: both considerations of social justice and other considerations involving social welfare afford a moral basis for individual action, because principles of professional ethics derive from normative principles generally.

Proponents of unrestricted advocacy include Eric Cassell [2] and Albert Jonsen [3, 4]. Cassell maintains that "Justice is not the relevant criteria" for deciding which patients receive limited medical resources, because when medical services run out "there can be no just solution" ([2], p. 79). "Justice is not the appropriate concept where illness is concerned", Cassell explains, because "the sick are not sick because of human agency and intent but overwhelmingly because of the actions of fate" ([2], p. 79). For example, if two persons are dying of diseases and there is medicine to save only one, denying medicine to either cannot be defended by appeal to justice. After all, "If the younger, more productive, smarter (use whatever criteria you wish) receives the treatment, you may argue the justice of the solution because he or she was due more. But the other patient dies – was that also his or her due?" ([2], p. 79). Cassell thinks not. He concludes that when painful decisions must be made, the moral basis of action is "love of humanity, compassion, and mercy, *not* justice" ([2], p. 79).

Jonsen defends a similar stance, arguing that factors external to the physician-patient relationship should never be decisive over patient welfare. External factors move toward greater decisiveness in the clinical setting only when all of the following conditions are met: (i) the achievement of significant goals of medical intervention is doubtful; (ii) the preferences of the patient are not and cannot be known; (iii) the quality of the patient's life approaches "the threshold considered minimal" ([4], pp. 144–145). In short, physicians should conceive of their primary responsibilities as twofold: patient care (i.e., diagnosis, treatment, prevention, and patient education) together with services contingent upon patient care (i.e., dealing with the social situation from which particular patient come and to which they must return). These primary responsibilities must be "fulfilled up to [their] limits before other responsibilities become ethically urgent. Responsibilities set by other principles, such as broader social and political responsibilities, do not justify curtailment, slackening, or termination of the activities demanded by this primary responsibility" ([3], p. 388).

In contrast to Cassell and Jonsen, Norman Daniels favors the position of restricted advocacy. This position portrays the physician's primary responsibility as obedience to principles of just health care. Yet, on Daniels' view, obedience to justice is not purchased at the price of abandoning a professional creed. For, properly understood, "the ... content of professional ethics ... [itself] depend[s] on what kinds of institutions are needed to guarantee the just distribution of the goods provided by those relationships" [5]. Or, to put this point another way: "It is justice that should be primary here ... and professional ethics should govern roles circumscribed by just institutions" ([5], pp. 74–75). So a physician who fails to maximally serve a patient's interest, for example, by not making certain treatments available, is not necessarily in violation of professional ethics. Indeed, professional principles may require a physician to do just that. Hence, Daniels rejects both Cassell's and Jonsen's versions of unrestricted advocacy. Whereas Cassell directs physicians to dispense with justice and be guided by compassion, Daniels implies that dispensing with justice is not an option, because justice inheres in our very conception of the professional's moral role. Whereas Jonsen instructs physicians to fulfill their responsibilities as physicians first and only afterwards consider matters of distributive justice, Daniels suggests that this ordering is nonsensical because physicians aspire to conform to principles of justice whenever they aspire to conform to professional ethical principles.

A final view, called maximally restricted advocacy, finds the proper balance between patient advocacy and public service to be weighted still more in the direction of society at large. Paul Camenisch [6] is a notable advocate of maximally restricted advocacy. On his view, physicians are under a strong duty to promote the welfare of the broader society, and this duty sometimes overrides their responsibility to promote the interests of specific patients. This claim rests on two arguments. The first argument is that a commitment to serve the public interest has historically gone hand in hand with physicians' commitment to promote patient welfare. As a consequence of this historical commitment, citizens presently *expect* the medical profession to promote the public good in matters of health. These expectations have normative force: "if such expectations of the professional ... are in fact widely current, then they become part of a societally defined role, a set of rights and duties, which the professional takes on when, in the context of this society, he presents himself as and functions as a professional" ([6], p. 19).

A second line of reasoning appeals to the fact that the physician is not "a self-made man". That is, physicians' training and education are not accomplished without extensive assistance from society. For example, "Massive amounts of money, both public and private, are regularly spent to fund professional education ... to fund the research on which professional practice rests, the institutions in which and the structure through which much professional activity occurs and, increasingly to fund specific individual demands for professional service" ([6], p. 22). As Camenisch sees it, "All of these activities of the society constitute unearned benefits or gifts given to the professional" ([6], p. 22). Accepting such gifts places professionals under an obligation to the society granting them. Specifically, professionals are obligated to use these benefits in a manner consistent with the intention of those who have given them. Assuming that the intention of such investments is to benefit society at large, Camenisch concludes that professionals are under an obligation to use their skills and resources to that end and to avoid benefitting specific persons at the public's expense.

PROBLEMS WITH UNRESTRICTED ADVOCACY

We are now prepared to ask which of the above models provides the most cogent account of physicians' moral function. I believe it can be persuasively shown that the third account is superior to the other two. Patient advocacy should be maximally restricted, as opposed to unrestricted or minimally restricted. I shall support this proposal by pointing out some salient problems with the alternative viewpoints, and then extending the argument for maximally restricted advocacy.

Consider first Cassell's proposal. Cassell insists that justice should have no bearing whatsoever on a physician's decision about resource allocation. His reasoning is that people do not *deserve* in the first place to be disabled or ill; hence, they deserve to be cured or compensated. To deprive them of medical goods that would achieve this is to fail to give them their due. Now the difficulty this position encounters is that it relies upon an extremely narrow understanding of justice. To make this point most perspicuously, it is useful to interpret justice in more general terms and to see where Cassell's interpretation fits within this broader interpretation. Broadly understood, justice includes both formal and material senses. The purely formal sense bars arbitrary discrimination by requiring that like cases be treated alike. Clearly, however, no two cases are alike in all respects; a second dimension of justice, material justice, specifies when cases qualify as relevantly similar. For example, canons of material justice might hold that persons should be treated the same provided that they have like needs or provided that they are alike in achievement or effort or productive contribution. Merit is another possible basis for calling two cases similar. It asserts that two cases are relevantly similar if persons are equally meritorious. This is apparently the conception of justice Cassell entertains. His argument can be restated, then, as follows.

1. Merit is the primary determinant of individual claims to medical services.
2. No one deserves that an illness befall them.
3. So all deserve compensation or cure.
4. Therefore, curing or compensating one person rather than another necessarily fails to give the other his or her due.

This reasoning can be faulted on several grounds. First, it fails to furnish an argument establishing the controversial first premise, i.e., establishing that merit is the primary criterion for determining that two cases are relevantly similar. Other possible criteria are equally plausible. For instance, why not supplement merit with need? Then distributions qualify as just provided that of two equally deserving patients the one with greater medical need receives a limited resource. A second reason for doubting Cassell's position is that even if we were to grant, for the purposes of argument, that merit is the primary measure of comparative justice, it does not yet follow that treating one person rather than another fails to give the other his or her due. After all, some patients may in fact be more deserving than others. This will depend largely upon what we take as the basis for determining merit. For example, perhaps patients who are more disposed to adhere to a medical regimen and realize the benefits of treatment are more deserving of treatment; or perhaps patients who have more life ahead to live are more worthy than those whose death is imminent. As it stands, the principle of merit is far too vague to serve as a directive for action. Cassell has hardly shown then that justice is moot in the context of medical decision-making. He has shown only that the material principle of merit offers no straightforward or decisive account of what justice requires in that context.

In response to this, Cassell might acknowledge that in times of scarcity not all persons can be given the medical care they are prima facie entitled to receive. Nonetheless, where rationing must occur it is not the physician's business to decide who will be deprived of what. Instead, physicians should let others (society, hospital administrators, or whomever) decide these questions and should defend their patients' interests as zealously as possible against restrictions imposed from the outside.[2]

This response bolsters the argument for unrestricted advocacy by allowing that other roles in the health care system will provide the needed checks and balances on patient advocacy. Considerations of justice can enter the system but need not enter it through the physician's role. Although this proposal is more persuasive on its face, it encounters important objections. First, even if it were possible for the physician to wholly delegate rationing decisions, it would be inappropriate for the physician to do so [8]. This is because even if hospital administrators or society at large were vested with the primary responsibility in making distributive choices, the need for physician input and compliance is not obviated. On the one hand, physician input is needed because physicians are in a better position to judge the medical costs of cutting different forms of care, the medical risks associated with policies of early discharge for different patient populations, and the general clinical consequences of alternative schemes. On the other hand, physician compliance is needed because physicians who are not committed to the system can always find ways of working around it. For example, a physician at an economically pressed public hospital who is completely aloof to social justice concerns might press for obtaining the highest cost antibiotics (which may cost over $2,000) where much cheaper antibiotics are almost, but not quite, as effective. The physician can, for example, distort the medical value of more expensive medication, make much of the risks associated with the cheaper drug, or exaggerate the health problems of the patient.

A second objection the revised account encounters is a practical one. It is simply unrealistic to suppose that physicians ever are or ever could be completely uninvolved in rationing medical resources.[3] This is because even in the absence of an explicit cost containment role, the physician is an integral player in an informal process that denies beneficial care to patients. Physicians inevitably limit care to patients because there are limits on their human time and energy. Moreover, patients are denied beneficial care on the basis of factors such as ability to pay; residence; risk and legal liability; anticipated clinical outcome; and first come, first served protocols.

Let us next turn to Jonsen's argument for unrestricted advocacy, which offers an initially more promising defense of that view. Jonsen maintains that professionals should first discharge their responsibilities as professionals and only afterwards consider "external factors", such as distributive justice. He thus presumes that distributive justice is external to professional ethics. But where is the argument for this? Jonsen's reasoning overlooks a critical question: What are foundational principles of professional ethics? Why should we suppose that professional ethics comprises a set of moral principles that stand apart from the general normative principles, such as justice, that apply to non-professionals? Unlike Cassell, Jonsen understands that the conceptual foundations for an ethics of medical care covers "an ancient Roman's definition of the entire field of ethics: Honeste vivere nemini laedere, suum cuique tribuere – live uprightly, hurt no one, give to each his due" ([14], pp. 169–170). However, Jonsen does not devote critical attention to how virtue, duty, and justice relate to each other; he does not consider in a systematic way their respective places in an overarching theory that encompasses each.

A common sense argument supporting Jonsen's (implicit) view, i.e., the view that role-defined virtues and duties take precedence over distributive justice is outlines below [15].

1. Ensuring the continued existence of institutions, such as the medical system, is important and valuable.
2. Ensuring this requires that those who occupy special roles within the system (e.g., physicians) be exempt from certain general moral requirements.
3. Therefore, conduct that would be morally suspect, judged from general moral principles, is justified when considered as a necessary part of a whole institution that is morally valuable.

So, for example, medical practitioners are not held to principles of justice because to hold them accountable in this way would undercut their primary job of patient care and advocacy.

A chief problem with this argument is that many institutions could continue to operate successfully with considerable reduction in the extent to which their roles are exempt from criticism by general moral principles. Physicians could give up a great deal of their present tendency to zealous patient advocacy and the virtues of the medical system remain intact. For instance, trust is not eliminated from the physician-patient relationship even though physicians are required by law to report certain sexually transmitted diseases; cases of child abuse or neglect; and injuries, such as gunshot wounds. Similarly, patients could continue to rely on physicians to staunchly advocate their interests, even if public rules were in force that constrained physicians' use of medical resources. Physicians should not be expected to hoard and poach what is reserved for other patients, nor to defraud third party payers of resources they are neither contractually nor morally obligated to provide in the name of keeping the physician-patient relationship sacrosanct [16]. Not only could positive features of the physician-patient relationship remain *intact* with reduced emphasis on patient advocacy, the medical system itself would come closer to realizing our conception of what such a system should be like. We think that, ideally, medical professionals should be skilled at identifying and evaluating complex moral considerations appropriately, rather than ignoring such considerations. For example, we respect more a physician who, in deciding whether to prescribe a far less expensive anti-hypertensive medication which will control hypertension as well but which is likely to have more unpleasant side effects, acknowledges the ethical tradeoffs implicit in this decision. Generally speaking, we think a system made up of persons aware of a broad range of moral factors that impinge upon their practice would be a better system. That is, a system whose functionaries appreciate the moral tensions inhering in their roles and hone skills for handling them gains in moral respectability. All of us benefit by living under a just health care system, although such a system will sometimes be contrary to our narrowly defined self-interest.

PROBLEMS WITH MINIMALLY RESTRICTED ADVOCACY

At first blush, it might be thought that these considerations establish that minimally restricted advocacy constitutes an ideal alternative to unrestricted advocacy. According to this middle view, patient advocacy should be circumscribed by principles of justice. Yet before making this judgment, we need first to consider whether justice *alone* justifies restrictions on patient advocacy. Although Daniels does not state outright that justice provides the only grounds for limiting patient advocacy, his failure to suggest any other grounds can be read as supporting this view. Furthermore, at various places he comes very close to endorsing such a view: "The problem with current cost containment measures", he writes, "is that they are not part of an overall effort to make the U.S. health care system more just" ([5], p. 78). Elsewhere, he adds that physicians are right to feel uneasy about patients beneficial care under current cost containment schemes because the assurance that such demands are fair is "most definitely lacking" ([5], p. 78). These passages suggest that *unless* denial of beneficial care is supported by principles of justice, it is not morally supportable at all.

As Camenisch's argument to the contrary make evident, this unstated premise is by no means uncontroversial. I shall argue that allowing only considerations derived from a theory of justice to put a rein on patient advocacy is contrary to our considered judgment. Let me begin by first spelling out the difference between a theory of justice and a broader moral conception. Then I shall go on to point out considerations we accept as limiting patient advocacy that spring from a broader moral foundation.

Unjust actions are distinct from other wrong actions by virtue of the reasons that make such actions wrong. Unjust actions are wrong because they constitute: (1) invidious discrimination or arbitrarily unequal treatment in legislating, administering, or enforcing rules, or in distributing burdens or benefits; (2) exploitation, that is taking advantage of another's trust or natural handicaps to gain unfairly at his expense, or placing another at an unfair advantage in competitive or cooperative undertakings; (3) judgmental injustice, which consists in making false derogatory judgments about persons or their works, statements that 'aren't fair' to the persons they are about ([17], pp. 802-803).

Objections to patient advocacy that stem from considerations of justice will fall into three groups, corresponding to the three-fold classification noted above. A first type of objection denies the legitimacy of patient advocacy that violates a relevant principle of material justice. For instance, if 'like cases' are determined to be cases where patients are alike in medical need then a physician who in a situation of scarcity does not hesitate to administer flu shots to young healthy patients who need them much less than older or immuno-suppressed patients and does this because the young patients are his own, is guilty of invidious discrimination. A second form of patient advocacy justice forbids is illustrated by the case of a family physician who treats a married couple and learns that one partner tests positive for AIDS. If the physician responds to the second partner's expressed concern about contracting AIDS by offering reassurances, the physician exploits the trust of one patient in order to protect the interests of the other. Finally, justice bars patient advocacy that is accomplished by tactics of smearing or defaming a third party. Although this type of injustice may be less common in a medical setting than the other two, it is illustrated by a cardiac surgeon who undertakes to increase her patient's chance of receiving a heart transplant by false innuendos to the effect that another transplant candidate is stupid or dull.

Having examined the special ways in which unjust actions are wrong and the application of this to patient advocacy, we are now ready to return to the claim I made a moment ago. I said at the outset that there are cases where patient advocacy is excessive and objectionable, but not unjust. In consequence, I objected to Daniels' position, which holds that justice is the only legitimate basis for curtailing patient advocacy. My objection can now be sustained by calling attention to situations where we agree that it is appropriate to restrict advocacy, but none of the three reasons of justice sketched above apply. The following examples fall into this category.

Consider, first, a situation where justice is compatible with virtuous action, but is equally compatible with vicious action. Suppose that justice entitles a certain patient to life-sustaining treatment because the patient owns (or is able to pay for) the treatment, however, this patient will die shortly regardless of receiving the treatment due to another medical condition the patient suffers. As a direct consequence of giving the treatment in question to this patient, another patient who needs the same treatment will be deprived of it and suffer a slow and torturous death. Suppose these patients are served by the same physician. Suppose further that, unlike the first patient, the second patient could potentially lead a long and productive life. Here, the morally *upright* course of action on the part of the patient who will die soon may be to prevent the death of the other patient. Although the first patient's clinging to the last days of life tenaciously and refusing to forego life saving treatment would not be contrary to justice, it would be morally indecent. Moreover, moral sensitivity on the part of the physician would consist in persuading the patient to forego beneficial treatment and supporting such a decision, even where this decision does not promote the patient's own best interest. If this is correct, then virtue and moral decency, as well as justice, can authorize restrictions on patient advocacy.

It may be replied that if the dying patient *voluntary* foregoes a claim to treatment, then the physician is not restricting patient advocacy in going along with her decision. The idea here is that support for a patient's autonomous choice is part of patient advocacy. But this reply overlooks a crucial difference between beneficence and autonomy. Beneficence requires physicians to promote their patients' welfare regardless of whether patients prefer that their welfare be advanced; autonomy calls upon physicians to respect patients' competent choices regardless of whether doing so furthers patients' welfare. These principles can and often do conflict. A physician who undertakes to zealously promote a patient's interests will oppose, on principle, a wish on the part of the patient to selflessly sacrifice her interests for the sake of others.

Consider next a situation where the utilitarian consequences of serving justice are extraordinarily cruel or highly unrealistic. Suppose, for example, that justice calls for a policy of treatment based on medical need in war time. A consequence of enforcing such a policy might be devastation of troops, loss of critical territory to the enemy side, and eventual defeat. In such a situation, *just* patient advocacy might be legitimately curtailed by appealing to broader moral considerations. The deleterious consequences of allowing just advocacy may simply be too great; we cannot serve justice under any and all circumstances.

AN ARGUMENT FOR MAXIMALLY RESTRICTED ADVOCACY

The foregoing remarks make clear that neither the unrestricted nor the minimally restricted model accurately depict the proper balance between patient advocacy and social responsibility. In order to locate this balance we need a better sense of the values that anchor medical ethics at a deeper level. I will proceed to sketch the broad contours of an argument for maximally restricted advocacy. Let me begin by stating the argument in outline form.

1. Physicians undertake a dual commitment: to serve as patients' advocates and to serve the public good.

2. Then both patients and members of society at large possess rights that hold against physicians and derive from physicians' commitment. In particular, patients possess a right to care and advocacy, while others possess a right to service in the public interest.

3. Therefore, physicians are obligated to promote their patients' interests only when doing so does not violate the moral rights of others; likewise, physicians

are obligated to serve the public good only when doing so does not infringe the rights and dignity of their patients.

The crucial first premise garners support from the fact that promoting the social good has long been part of medical professionals' avowed commitment. Through oaths taken, codes of conduct adopted, and public statements issued, the medical professional transforms what Camenisch calls "historical commitment" to present commitment. For example: the American Medical Association Principles of Medical Ethics declare that "The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man"; the commentary of the judicial council reads, "The avowed objective of the profession of medicine is the common good of mankind"; moreover, "The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual but also to society where these responsibilities deserve his interest and participation in activities which issue the purpose of improving both the health and the well-being of the individual and the community" ([6], pp. 20–21).

Premise two affirms that the parties to whom professionals make commitments have subsequent rights. The professional's promise literally alters the moral landscape. It is important to notice that the professional's commitment to further the public good can be met in a variety of ways. The creation of a just health care system is one of the more obvious ways. But the public good is also affected by: the social form health care delivery takes; the standards of entry and continuance in professional ranks the medical community sets; the degree to which medical knowledge is transmitted and furthered; the extent to which medical experts contribute to public debates on matters affecting health; and the profit margin medical institutions and practitioners seek. All of these diverse elements influence the moral fiber of the medical system and the character and integrity of its ranks. All constitute relevant standards for assessing how staunchly the professional's commitment to the social good is upheld.

The conclusion of the argument identifies, in the most general terms, the balance physicians ought to strike between patient advocacy and social responsibility. The view that emerges is that the rights-based foundation that establishes physicians' duties in the first place also reveals their scope and limits. Just as social responsibility underscores the limits of patient advocacy, respect for patients defines the borders of social responsibility.

One objection the foregoing argument may produce is the following.[4] If we allow, as the first premise does, that the source of patients' rights against medical professionals is the actual or historical commitment professionals undertake, this provides no guarantee whatsoever that these rights will be secure or adequate. After all, medical professionals might well have defined their commitment to patients extremely narrowly or they might in the future decide to do so. Then rights-based objections to medical professionals' conduct are undercut. For example, if physicians in the future publicly choose to put profit before patient care, then any negative impact this brings to patients cannot be objected to by appealing to patients' rights. Why, we might then ask, should the scope and limits of patients' rights be determined by the commitments professionals or their representatives decide to undertake?

At first glance, this objection carries considerable weight. Upon further reflection it carries much less. For the argument I am advancing does not purport to give an *exhaustive* account of patients' rights. Surely, one would expect the source of these rights to be multiple and varied. For instance, if there is a right to a decent minimum of health care, this right will not issue forth from a professional commitment to provide a decent minimum. It will instead be rooted in principles of justice which themselves derive, say, from the choices of hypothetical deliberators operating under a veil of ignorance. Likewise, the right to service in the public interest will be grounded only partly in actual commitments professionals make, it will also follow, for example, from principles of justice, moral ideas, and moral virtues.

Another objection to which my argument may fall prey is that even if we agree that physicians undertake social responsibilities, these responsibilities can be fully discharged outside the clinical context.[5] For example, at the bedside physicians can serve as unrestricted advocates of patients' interests, so long as at the public podium or in the medical laboratory they contribute to the social good – e.g., by elevating the level of public debate or increasing the scope of medical knowledge. In other words, there are many ways to fulfill a duty to promote the public good other than restricting patient advocacy.

Although this objection rightly notes that social obligations can and should be broadly conceived, it wrongly claims that physicians' social responsibilities can be fully met outside the clinical encounter. An implication of this claim is that if patient advocacy results in various public harms this can always be adequately compensated for by performing other services that advance, rather than hinder, the public good. But surely this implication does not hold in all cases. Bad consequences cannot always be offset by good ones. Especially where justice and rights are at stake, one needs to avoid committing unjust acts or violating rights in the first place. For example, if staff time and energy is lavishly bestowed upon a particular patient to the detriment of others as a consequence of a particular physician's zealous advocacy, the physician in question must be told to desist from such forms of advocacy and allow staff to devote time to other patients. It is not enough for the physician to work extra hours in the laboratory or preach social justice to the public, while continuing to produce injustice in the hospital where she works.

A final objection to the argument I am proposing is that it says nothing about what justice requires a physician to do in dilemma situations. For example, situations in which two or more patients cannot all have their entitlement to care met due to limited medical resources. A dilemma arises in such cases if the parties concerned are all *equally* entitled to their share of the relevant resources. It would not arise if their rights were ranked in some order of priority.

In response to this concern it might be said, on the one hand, that when a choice has to be made under such circumstances the principle involved is a justice principle having to do with sub-ideal realization of rights. According to this response, a complete theory of justice includes both principles of ideal and non-ideal justice. The latter principles identify the best possible resolution in cases where perfect justice cannot be realized. On the other hand, it might be maintained that justice does not apply at all in dilemma cases. The reasoning supporting this is that the circumstances of justice do not obtain in such cases, but such circumstances must obtain for justice of any sort to arise. For example, one of the circumstances of justice is moderate scarcity. It might be argued that extreme, rather than moderate, scarcity is present in cases where two persons with equal claims to resources find that both of their claims cannot be met. Notice, however, that each of the responses I am suggesting is troubling in a deep sense. For both make evident the impossibility of locating a fully satisfying solution in a certain group of cases. A more complete discussion of this problem is surely warranted, but it is also well beyond the scope of the present project.

I have sketched and defended an argument intended to show that professional ethics is anchored by moral rights that grow out of a dual professional commitment. This commitment is self-limiting, because the rights it confers must be balanced against each other. My argument obviously warrants further study and elaboration. Nonetheless, it does suggest an avenue for supporting the position that professional ethics conforms to the model of maximally restricted advocacy. It should be seen as a step (one only) in a wider effort of integrating role-based medical ethics with normative ethical theory.[6]

THEORY AND PRACTICE

In closing, I want to point out that at one level this discussion borders on the obvious. It may seem obvious that physicians have social responsibilities that transcend patient care. At another level though, these remarks are all too easily forgotten. In the clinical setting, especially, the temptation is to make decisions exclusively in terms of patients' interests. When external factors conflict with patient care, the inclination is to discredit the former and promote the latter. This is evidenced by the fact that, by and large, the current system places the burden of proof on those who would do less than maximally advocate patients' welfare.

This structure may well be optimal. But, all too often, it makes discharging other commitments an unpopular and suspect course. Plainly, we don't want individual physicians deciding willy nilly how to ration the medical care at their disposal. Achieving social justice requires instituting global policies and calls for public debate, not backstage bartering. But medical professionals are ultimately the ones who must rise to the occasion and implement restrictive social policies. Calling attention to foundational principles that prescribe broad social responsibilities should afford a more supportive framework for carrying them out. It should prove a first step toward persuading physicians to reflect these principles in practice.

Acknowledgements – Early drafts of this paper were written during the spring and summer of 1988 while I was a Rockefeller Fellow at the University of Maryland Institute for Philosophy and Public Policy and a visiting researcher at the Georgetown University Kennedy Institute of Ethics. I am grateful to members of both institutes for affording me an exceptional opportunity for philosophical reflection and dialogue. I am also indebted to Professor Albert Jonsen for valuable feedback. This paper was presented in October 1988 at the Kennedy Institute of Ethics, and at a March 1989 meeting of the North American Society for Social Philosophy in Oakland, California.

NOTES

[1] For example, the World Medical Association Declaration of Geneva (amended 1983) states: "The health and welfare of my patient will be my first consideration" ([1], p. 193).

[2] An argument to this effect is suggested by Marcia Angell [7].

[3] This point has been made previously by a number of others [9-13].

[4] I am grateful to Robert Veatch for calling this objection to my attention.

[5] Ruth Faden suggested this line of reasoning to me and pointed out its potential appeal to medical professionals.

[6] For a general discussion of this effort, see [18].

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