Copyedited by: VR

Journal of Medicine and Philosophy
doi:10.1093/jmp/jht024

The Limits of Social Justice as an Aspect of Medical Professionalism

THOMAS S. HUDDLE*
University of Alabama-Birmingham, Birmingham, Alabama, USA

*Address correspondence to:

AQ2

Contemporary accounts of medical ethics and professionalism emphasize the importance of social justice as an ideal for physicians. This ideal is often specified as a commitment to attaining the universal availability of some level of health care, if not of other elements of a "decent minimum" standard of living. I observe that physicians, in general, have not accepted the importance of social justice for professional ethics, and I further argue that social justice does not belong among professional norms. Social justice is a norm of civic rather than professional life; professional groups may demand that their members conform to the requirements of citizenship but ought not to require civic virtues such as social justice. Nor should any such requirements foreclose reasonable disagreement as to the content of civic norms, as requiring adherence to common specifications of social justice would do. Demands for any given form of social justice among physicians are unlikely to bear fruit as medical education is powerless to produce this virtue.

Keywords: *medical ethics, professionalism, Rawls, social justice*

I. INTRODUCTION

Although the ethics of medical practice exhibit continuity with the past, they also change as societies change. This is especially evident in the United States and Europe in the past 50 years. In 1960 medical ethics were the province of physicians who self-consciously appealed to a tradition going back to Hippocrates in formulating their codes of ethics. That tradition underwent vigorous criticism in the 1970s and after, as shortcomings in medical ethics were held to be in part responsible for various ills of late-twentieth-century medicine. Traditional medical ethics were blamed for being authoritarian, parochial, and paternalist (Veatch, 1984, 41–2). There was a widespread

© The Author 2013. Published by Oxford University Press, on behalf of the Journal of Medicine and Philosophy Inc.
All rights reserved. For permissions, please e-mail: journals.permissions@oup.com

Copyedited by: VR

sense that medical ethics were too important to be left to physicians and that in fact medical ethics belonged less to medicine than to ethics considered more generally—thus falling under the purview of philosophers and the public, as well as of physicians.

Medical ethics has incorporated much of the critique mounted against it in the 1970s and after; among the changes in the way medical ethics are currently formulated is a new emphasis on medicine's relations with society—generally set out in formal statements of medical commitments as a concern with social justice (Medical Professionalism Project, 2002, 520). In what follows I will question the inclusion of a common contemporary account of social justice among the professional norms by which physicians should be governed. Justice, I shall maintain, is better thought of in contextualist than in universalist terms; that is, its demands will vary according to the context in which appeals to justice are made (Miller, 2002). Social justice, however it is conceived, is not the form of justice demanded by the context of medical practice. That is not to say that physicians have no debt to society or that justice is not important in their work. It is to say that the medical profession's obligation to society is best conceived in terms other than those of social justice, and that justice in medical practice differs from what is demanded by the norm of social justice.

I begin with a discussion of the sources of medical ethics, in which I argue that no account of medical ethics is plausible that does not engage with the actual moral commitments of physicians of given times and places. Although the ethics of medicine are rightly subject to criticism by anyone, they cannot be properly formulated apart from the perspective of the practitioner. From this starting point, I go on to explore the role of justice among the norms of professional work to which physicians have offered allegiance. I observe that physicians value justice in medical practice, but that they so far have not accepted the norm of social justice as that concept is commonly explicated by its advocates. I then offer an argument that the particular account of social justice now being urged on physicians does not belong with the medical ethics to which all physicians should adhere—because social justice is a norm of civic rather than professional practice; because social justice is a deeply contested notion about which disagreement is inevitable; and because the virtue of social justice is beyond the power of medical education to produce.

II. SOURCES OF THE NORMS OF MEDICAL ETHICS AND PROFESSIONALISM

There is at present lively debate over the sources of medical ethics and professionalism. Do our professional commitments stem from the ends of medicine, which may be discerned and from which medical ethics may be deduced (Pellegrino, 2001)? Do they follow from moral rules derivable from

Copyedited by: VR

a moral theory premised on harm-avoidance (Gert, Culver, and Clouser, 2006, Chapter 2)? From the standards that emerge through negotiation among disparate moral communities in a society (Engelhardt, 1996, 67–84)? Or from universal ethical principles that may be developed out of common moral intuitions (Beauchamp and Childress, 2001, 2–5, 401–6)? I suggest that any position on the source and content of medical ethics that recommends itself to us on abstract grounds must also contend with the actual moral commitments of medicine as exhibited in practice and taught in academic medical centers—as those who teach medicine do convey a distinctive morality to trainees, whether or not they spend time thinking or talking about it explicitly. Morality, medical or otherwise, cannot be approached as if one were choosing impartially among competing accounts thereof apart from any given moral practice. None of us is impartial as to what morality is, and no practicing physician is impartial about the morality of medicine. On the content of medical professionalism, every physician has "skin in the game" prior to any discursive consideration of it. Conceptual elaborations of medical ethics must therefore engage with the moral norms to which physicians already offer allegiance if they are to persuade.

It might be objected here that no normative conclusions can be drawn from the content of a given set of moral commitments. Conscience may be mistaken, as may be the social practices of occupations or even entire societies. Wherever we find our moral compasses to be, we can decide where they ought to be only through a process of reason and reflection leading to justified moral conclusions. As Edmund Pellegrino puts it, "ethics is not a set of visceral sensations arising somewhere in the solar plexus . . .Ethics is a formal, rational, systematic examination of the rightness and wrongness of human actions" (Pellegrino, 2006, 65). Although this caution is important, if it is taken to suggest that our actual moral practices should have no weight in our reasoning about moral norms, it goes too far. Ethical systems built up from first principles gain what purchase they achieve not through discursive coherence alone, but through contact with our deepest moral convictions. If it were possible to justify ethics deductively from agreed-upon first principles apart from the raw material of our moral practices and the intuitions that sustain them, we would all share common ethical conclusions—as is, of course, far from the case. As Charles Taylor suggests, moral argument must be ad hominem rather than apodictic—it must appeal to the moral commitments we actually have in making its case (Taylor, 1993). It is because physicians share moral convictions about their practice that they can connect to codes of medical ethics or charters of professionalism. The role of ethical thinking in formulating such codes and charters is not merely to deduce moral imperatives from abstract considerations but to engage with the actual moral practice of physicians as such thinking shapes and corrects their practice in the course of making their moral commitments explicit.

Copyedited by: VR

4.1 Such a proceeding might still appear to be perilously conservative and physician centered; what if the moral practice of a given medical profession is so badly mistaken as to require radical re-shaping; if so, the resources for doing so would have to come, it would appear, from outside the practice 4.5 itself. Social practices such as medicine fit within the broader context of human life, in which our many practices coexist and more or less cohere. Accordingly, practices may be assessed not only by internal standards but according to the role(s) the practice plays well or ill in the life of society. To use an example of David Miller's, if medicine excessively glorifies transplant 4.10 surgeons and devalues family doctors, that may be a professional deformation, even if each group practices impeccably (Miller, 1999, 123). Society, of course, shapes the important practices prevailing within it, even as they shape society, so that a given practice such as medicine is seldom wholly to blame if the role it plays in the larger society is not optimal. In the worst 4.15 cases of professional corruption, such as that of the Nazi doctors, the respective roles played by the profession and by society may be impossible to disentangle.

We may distinguish assessments of medical practice by internal standards from assessments made from a societal standpoint. Even the latter, however, 4.20 must engage with standards internal to the practice. If society demands of medicine services incompatible with internal standards—say, to take a controversial example, physician-assisted suicide or active euthanasia—then the profession may legitimately refuse. The societal vantage point is not privileged (or, for that matter, necessarily subordinated) in assessments of pro- 4.25 fessional morality. Patients and physicians alike share identities as members of families, neighborhoods, and voluntary associations; and, of course, they are citizens of given nations. The norms governing medical practice must be in conversation, as it were, with those governing other social relationships. The point is that an assessment of professional morality must contend with 4.30 the weight of the actual moral commitments of a given professional practice, both contemporary and historical; as it must also with the moral demands of society on such a practice and the manner in which these have been met. It would be comforting if there were an Archimedean point of pure theory from which professional (or any) morality could be weighed and corrected. 4.35 I do not believe that there is any such point; instead of seeking one, we must work at making sense of the moralities we inherit and inhabit and seek to improve and correct these as best we can, in a spirit of humility (as we may be far astray without realizing it). We are in the position suggested by Anscombe, who "imagines one of us deciding to do the best he can with 4.40 what he's got through acculturation and habituation, realizing that he will be lucky if this does the trick." She remarks:

> Such an attitude would be hopeful in this at any rate: it seems to have in it some 4.44 Socratic doubt where, from having to fall back on such expedients, it should be

Copyedited by: VR

clear that Socratic doubt is good; in fact rather generally it must be good for anyone to think 'Perhaps in some way I can't see, I may be on a bad path, perhaps I am hopelessly wrong in some essential way' (Anscombe, 1958, as quoted in Vogler, 2006, 360).

III. JUSTICE AND MEDICAL WORK

Beginning, then, from the moral commitments that physicians hold and to which they aspire, what can we conclude about these commitments as regards justice? In what ways do doctors find justice to bear on their practice? And what reasons can be offered to broaden the justice commitments that physicians now make and have historically made? The most obvious bearing of justice on medical practice is the requirement, generally accepted among physicians, that they distinguish patient claims for treatment only according to medical need. Physicians agree that their commitments to patients stem from their status as patients; sick human beings in need of healing. For doctors to offer any patient less than a full commitment to healing because of some other aspect of a patient's identity is an affront to justice. The academic medical institutions with which I am familiar do well in practicing and teaching this norm of medical practice—trainees are expected to treat everyone who is admitted to a clinical service or who presents to an emergency room and to do so in a fully committed way. The hospitals in which trainees work may make distinctions favoring insured patients; academic physicians generally deplore such distinctions and seek to mitigate their effects. The profession has not always acquitted itself well in doing justice to patients—we have fled epidemics and refused to treat patients with given diagnoses. In the early days of the AIDS epidemic, some physicians and institutions avoided or rejected AIDS patients; in 1986 the AMA briefly took the position that only physicians "emotionally able" to care for HIV-positive patients were required to do so (Huber and Wynia, 2004, w8). That position was inconsistent with historic declarations in the AMA Code of Ethics of physician responsibility to care for patients even at personal risk during epidemics. It was, however, rescinded quickly. No such equivocation was forthcoming from academic bodies of internists and infectious disease specialists, which declared forthrightly that physicians were obligated to care for any and all patients even at personal risk to themselves (Health and Public Policy Committee, 1986, 576). Although academic physicians practiced and taught that all who needed care must be cared for, it might be argued that such teaching was no virtue because academic institutions had no choice in the matter; their status as teaching hospitals required them to turn no patients away, whatever their staff might have wished. In spite of such constraints, I do not believe that my teachers in the late 1980s were insincere in telling us trainees that all patients in medical need had an equal claim on us

Copyedited by: VR

6.1 and that we had no business refusing to see or treat anyone on the grounds of their particular disease. Nor were most of us trainees unreceptive to that message—it fit well with the ethic of responsibility for our patients that we were in the process of internalizing.

6.5 Critics might conclude that this lesson in justice must be ill learned by medical trainees, as there is a voluminous literature on health care disparities that implicates the health care system and its workers as in part responsible for disparities in access to care. One conclusion of the Institute of Medicine Report on health care disparities that bias and prejudice on the part of health 6.10 care workers may contribute to such disparities (Institute of Medicine, 2003, 178) was taken by some to be evidence for moral failure on the part of the medical profession (Bach, 2003). In fact, the Report did not conclude that bias and prejudice are primarily responsible for treatment disparities; as one of the Report's authors later put it:

6.15

> There is little evidence that American physicians, as a group, openly harbor and act upon race-based hatred or contempt. There are outlier cases of crude bigotry, but preoccupation with these distracts attention from the larger story. Clinical uncertainty and discretion, race-related heuristics and attitudes, and communication failures across cultural and linguistic lines interact in complex ways to create disparity 6.20 (Bloche, 2005, s59).

What we ought to (or can) do about race-related heuristics, some of which may be statistically valid, is a vexed policy question (Bloche, 2005). No doubt health care workers need to be careful (or as careful as is humanly possible) to ensure that prejudice, conscious or otherwise, is not affecting 6.25 their clinical decisions. It is unlikely, however, that such prejudice is important among American physicians at the present time; certainly, clinical teaching in today's academic centers condemns and excludes it forthrightly. As Epstein observes,

6.30

> the attitudes of physicians today have shown a true revolution from those that permeated the generation or two ago, and that the influx of physicians from all races and all walks of life has transformed the internal culture, so that wary customers should have confidence in the incredible dedication that young physicians, in particular, show, notwithstanding their long hours and low pay (Epstein, 2005, s40).

6.35

IV. THE DEMAND FOR SOCIAL JUSTICE IN MEDICINE

I have contended that professional ethics concerns justice insofar as it requires physicians to treat medically alike patients alike. It is perhaps worth 6.40 noting that this position does not require individual physicians to accept any patient who appears in the office waiting room. Professional ethics (at least until now) has governed the doctor-patient relationship without claiming that physicians are responsible for initiating any particular such relation- 6.44 ship outside of emergency settings. Physicians accept and refuse patients

Copyedited by: VR

at their own discretion; they also “fire” patients for many reasons, including arbitrary feelings of incompatibility. Justice concerns demand not that physicians accept any prospective patient; they demand that prospective patients not be rejected for improper reasons. Of course, demands for professional commitments to social justice extend beyond the kinds of justice involved in treating medically like patients alike. In contemporary discussion the phrase most often refers to egalitarian theories of distributive justice, according to which the least advantaged in society ought to receive a “decent minimum” (or more), including health care, as a matter of right. Professional commitments to social justice are generally taken to obligate physicians to bring about such provision for the least advantaged in our society, or, at least, to advocate for it as regards health care; and to work toward the improvement of socioeconomic determinants of ill-health.

These demands appear in recent formulations of medical ethics and of the content of medical professionalism. The AMA’s principles of medical ethics in 1980 called for physicians to “participate in activities contributing to an improved community” (American Medical Association, 1980). The 2001 version of these principles asserted physician responsibility not only to participate in activities contributing to community betterment but also “support access to medical care for all people” (American Medical Association, 2001). This is in keeping with the Physician’s Charter, which asserts that medical professionalism demands availability of health care for all and that physicians individually advocate for such availability (Medical Professionalism Project, 2002, 521). How such demands might translate into the lives of individual physicians is not completely clear. Advocates of social justice have been cautious in suggesting that all physicians have a responsibility to engage in political activity. Gruen suggests that such activity is necessary but lists among activities that might fulfill such a requirement routine administrative duties (“working informally to improve systems of care within an institution”) or minimal forms of political participation such as voting in elections (Gruen, Pearson, and Brennan, 2004, 97).

Discussions of social justice in the context of medical education have often been more demanding. Those advocating education for social justice often begin by claiming that health disparities and the persistent poverty and inequality in American society that give rise to them are the result of systemic injustice (Wear and Kuczewski, 2004, 6; Kao, 2001). They go on to suggest that medical trainees should be taught their duty to rectify such injustice through political action. Wear quotes approvingly McCarthy’s demand for including “counter-hegemonic knowledge based on the experiences of the disadvantaged” in the medical curriculum. Such knowledge should induce discomfort in privileged medical students as they learn how their medical vision is shaped by their own place in an unjust social and economic hierarchy (Wear and Kuczewski, 2004, 7). Students should not only learn about social justice but act to pursue it; hence the curriculum should

require community service and encourage social and political advocacy as part of broader instruction in “socially responsible” medical professionalism (Coulehan et al., 2003, 28–34; Rothman, 2000, 1285).

Social justice as presently called for in training and practice is a major departure from the justice in treating patients that medical training now conveys and that, by and large, the American medical profession likely does well at providing. The obligation to those without access to health care that physicians have historically acknowledged is to offer some uncompensated care to such patients in the course of medical practice. Providing such care is not enjoined in the Hippocratic Oath but is so elsewhere in the Hippocratic writings. Similar commitments are made in Western codes of medical ethics up to and including the present AMA Code. Such commitments need not be conceived as a matter of justice; physicians have likely held to these commitments historically out of beneficence or humanitarianism rather than justice. Present declarations that bringing about health care availability for all is a core medical obligation clearly seek to broaden this historical commitment in the name of justice. Most medical professionals do not at present consider this contemporary conception of social justice to be a core aspect of their professional commitments (Gruen,~~ 2004~~; Wagner et al., 2007). One might suppose otherwise given the results of the survey of Gruen, ~~Pearson, and Brennan (2004)~~. Almost all physicians responding to that survey affirmed the importance of being “politically involved in health-related matters” (beyond voting) and of “encouraging medical organizations to advocate for the public’s health.” Self-reports of actual political and advocacy activity, however, tell a different story. Only ~25% of physicians responding to the same survey claimed involvement in either political or advocacy matters related to health. And other data suggest that in fact American physicians are less politically active than others with similar levels of income (~~Grande 2006; 2007).~~ If the measure of commitment to a professional norm is action, as it ought to be, we cannot conclude that the medical profession is so far committed to political action on behalf of health care for all. This is unsurprising, given the novel character of calls for such commitment and its prior absence outside of the small community of physicians interested in social medicine and public health. Ought the medical profession to transform its commitments in line with contemporary calls for social justice? Should certifying organizations begin requiring community service or political advocacy from physicians seeking certification?

AQ3

AQ4

The answer to these questions, I believe, must be in the negative, for the following reasons: (1) Social justice as conceived by its present-day advocates makes its claims upon society *in toto*, not on any given subgrouping in society such as the medical profession. As such, social justice makes claims on us not as physicians but as citizens. Making social justice a distinctively professional imperative is a category mistake. (2) Social justice is a deeply contested notion, about which agreement is unlikely to be achievable.

Copyedited by: VR

Reasonable, well-intentioned citizens have very different notions of social justice. For that reason, no particular conception of it should be taken as implied by membership in the medical or any other profession in our society. (3) Even if physicians agreed on a given vision of social justice and decided to require the character consistent with that vision in medical trainees, the virtue of social justice is far beyond the power of medical education to produce. Any attempt to do so will certainly fail—but may nevertheless interfere with other, more important goals of medical training.

V. SOCIAL JUSTICE ASSERTS ITS CLAIMS UPON US AS CITIZENS, NOT AS PHYSICIANS

However one conceives of social justice, including that norm among the core commitments of a particular profession implies some essential connection between it and the profession's mission and practice. I have suggested that the traditional commitment physicians have made to justice is to treat like patients alike according to medical need. Physicians also commit to offering some uncompensated care to the medically indigent, without necessarily connecting that commitment to justice. These obligations have an obvious relation to the practice of medicine. Those physicians who are governed by these norms connect to the broader tradition of moral medical practice with which Western physicians have always identified themselves.

The provision of health care for all, insofar as that is demanded by the norm of social justice, cannot be a function of medical practice in the way that these traditional norms have been. Health care for all will be achieved or not at the level of society rather than through the agency of the medical profession. As such, the public provision of health care is the proper province of citizens and their representatives in government rather than of members of the medical or any other profession. That is not to say that physicians ought not to further social justice as they conceive it, just as they ought to exhibit any virtue demanded of them by their status as citizens. Physicians, however, do not generally include civic virtues or obligations among the defining commitments of their profession, any more than they include ethical commitments incumbent on parents, association-members, friends, or spouses. Nor should they. Professional commitments should be those that bear directly on professional work, by which such work may be measured and through which physicians may be seen to be virtuous or not as professionals rather than as private persons.

How we collectively order our society, including arrangements we may make for the public provision of health care, is subject to norms of distributive, economic, fiscal and political justice. These norms bear on us as citizens rather than as members of any professional group, and I am aware of no reason to suppose that physicians have any special insight as to how these

Copyedited by: VR

10.1 norms ought to be realized in society. Physicians, of course, should contribute to societal deliberations as their expertise allows; they have special insight into the gravity of health care needs and their experience may usefully bear on what policies may best achieve public ends related to health care. What they cannot claim is special authority to determine what justice demands of society, what prudence may permit a society to do, or how health care ought to be weighed against other social priorities. Any advocacy in which they engage on such matters must be weighed according to its merits apart from the professional status of its physician advocates. If anything, society should be cautious in assessing physician opinion as to the public provision of health care as physicians have an obvious conflict of interest as direct beneficiaries of any such provision.

Of course, such considerations have not stopped physicians from claiming special authority on this and on a wide variety of other issues. Physicians seem especially susceptible to what Pellegrino calls a "seductive hubris," leading them to imagine that their expertise is grounds for determining the proper resolution of any social issue (Pellegrino, 1973, 144). Such hubris is misplaced. Physicians ought to keep their claims of expertise within proper bounds, and they should limit declarations of professional ethics to norms that bear on professional work. Social justice as presently called for in the Physician's Charter is beyond those limits.

Physicians have obligations to further social justice, but these obligations are those of citizens generally. Whether and to what extent such civic obligations include active participation in efforts to change society is deeply contested in present discussion of citizenship and civic justice. There is no compelling reason to insist that physicians in particular have obligations to actively foment social change. Thus the Physician's Charter is mistaken to command individual physician action on behalf of social justice. The medical profession has room both for political activists and for those who choose to work hard at their profession and devote their remaining time to family and interests of their own choosing. The profession's value to society resides not in any political stance that doctors may take and advance, but in the character and quality of the professional work that physicians do. Of course, the Physician's Charter enjoins not only physician action to further social justice but action on behalf of a particular social justice vision. This is also an error.

VI. PHYSICIANS MAY LEGITIMATELY HOLD ANY ONE OF VARIOUS CONCEPTIONS OF SOCIAL JUSTICE

Justice is a virtue notoriously resistant to analysis in such a way as to command consensus. Social or distributive justice is especially controversial. The seminal works of Rawls and Nozick in the 1970s have been followed by an explosion of theoretical and empirical work on social justice; the

Copyedited by: VR

contemporary scene manifests a wide spectrum of opinion as to what social justice is and what it may demand of societies (Lamont, 2004). The most important account of social justice as regards medicine is that of Norman Daniels, who over many years has elaborated an argument for health care as a basic right (Daniels, 1981, 2001). Drawing on Rawls's theory of justice, Daniels posits that meeting health care needs ought to be regarded as essential for fair equality of opportunity and thus a matter of social justice.

Rawls's theory seeks to elaborate the conditions under which inequalities in a society might be morally justified (Rawls, 2005). His principles of justice guarantee basic liberties (such as freedom of thought and liberty of conscience) and fair equality of opportunity. Fair equality of opportunity is distinguished from formal equality of opportunity (careers open to all). Fair equality of opportunity demands not only that careers be open to all, but that all with equal talent and ambition have a fair shot at achieving them. Thus fairness, in Rawls's view, requires compensation for economic or social deprivation that diminishes opportunities to compete. Once the playing field has been leveled by such compensation, inequalities resulting from exercise of the basic liberties and fair equality of opportunity are then acceptable if the difference principle is observed: that inequalities redound to the benefit of the least advantaged in society. Daniels departs from Rawls in arguing that opportunity should not be considered as merely instrumental to the competition for primary goods (basic liberties, income and wealth, jobs and offices). For Daniels, health considered as normal species functioning has a special status among the elements that make it possible to seize opportunity; on the grounds of that status, it deserves to be guaranteed by justice along with whatever else is necessary to provide fair equality of opportunity. Daniels' argument has been taken by many to be a conclusive justification for societal guarantees of a decent minimum of health care for all as a matter of justice (e.g., Beauchamp and Childress, 2001, Chapter 6).

Ought we to hold that justice as demanded in medical practice commits physicians to some such position as that held by Daniels? It might be contended that current formulations of social justice as a principle of professionalism demand support of health care for all but not of a particular rationale for such support; and that such formulations are not, therefore, unreasonably demanding. This contention is, however, implausible unless supporting health care for all as demanded by the Physician's Charter is simply to be in favor of it—as one might be in favor of any desirable outcome without necessarily favoring any given means of bringing that outcome to pass. Such a commitment would be merely vacuous. If professionalism statements demanding support for universal health care are to be interpreted substantively, they would appear to require not merely that physicians support the achievement of universal health care, but that they support it as a matter of social justice; that is, that they adhere to some such argument as Daniels makes.[1]

Copyedited by: VR

The difficulty with any such requirement is, of course, that it brings physicians down from the plane of moral and ethical norms to which they (or citizens generally) might reasonably be asked to adhere, to a disputable interpretation of what concrete measures are demanded by such norms; it is simply unclear that health care as a matter of right is demanded by distributive justice. Rawls and Daniels exemplify egalitarian developments of liberal political theory that began in the late nineteenth century as classical liberalism began to give way to more contemporary welfare or "redistributionist" liberalism. Classical liberals championed rights not to be interfered with in the pursuit of one's chosen good; welfare liberals agree that such rights are important, but argue that more is necessary for pursuing one's aims than mere freedom from interference. Basic goods such as food, shelter, and health (or health care) are a precondition for such pursuit; access to these should be no less a matter of right than the negative freedoms granted that status by classical liberals. These latter freedoms ought not to be considered fundamentally different from rights to basic goods, because government action is no less necessary for their guarantee (Sen, 2004, 345ff).

Although there is likely consensus on the importance of negative freedoms as rights (such as those in the Bill of Rights) in our society, the welfare liberal position on rights to basic goods has been far more controversial; the difficulty being that any such guarantee of basic goods must of necessity interfere with those tasked with their provision. Unlike negative rights, which demand only noninterference, positive rights cannot be institutionalized without extensive interference in the lives of those producing the goods so guaranteed. Objectors to positive rights argue that the institutionalization of such rights will interfere unacceptably with negative rights (of noninterference) and diminish the supply of those goods to which rights are granted. Such goods are scarce and it will be difficult to extend them to all who might be granted rights to them without extorting them from producers, thus discouraging production and, hence the supply of such goods (O'Neill, 2005).

The versions of positive rights theory put forward by Rawls and Daniels are vulnerable to more specific objections. The principle of fair equality of opportunity as explicated by Daniels follows from Rawls's contention that the contingencies of talent and social position that condition our success in life are "morally arbitrary." Because our social and natural endowments are, in effect, the outcome of a lottery, we do not deserve them, and the differing distributive shares that result from these are unjust (Rawls, 2005, 72). Fair equality of opportunity requires society to compensate those who lose in the natural lottery. Hence the importance of affirmative action for the socioeconomically deprived, subsidized education, and other like measures aimed at leveling the playing field for those who begin the competition for life's goods at a disadvantage. Daniels extends this analysis to health care on the grounds that normal species functioning has a special status among the

Copyedited by: VR

conditions of opportunity. The difficulty with requiring physician adherence to some such view is that there are plenty of grounds for disputing it. 13.1

Although we may not deserve the social position conferred by our parents or our natural endowments of talent and health, it simply does not follow that those without talent or health or social position have suffered injustice by virtue of their lacking those things. Rawls himself claims not to regard such ill-fortune as injustice (Rawls, 2005, 102), but, in going on to suggest that it is incumbent on society to compensate those who begin with lower social position or fewer talents, on pain of being unjust, he may be urging a distinction without a difference. If society is unjust for failing to compensate those who have done poorly in the natural lottery, the lottery itself is implicated in injustice. This result is deeply counterintuitive; we are more likely to suppose that justice and injustice do not apply to the hand we have been dealt by life; that what we are owed by society as a matter of justice is a fair chance at making what we can of our natural endowments, not correction of them. Most of us acknowledge that those less fortunate do have a claim on us, but we are more likely to view that claim as grounded in charity, benevolence, or humanitarianism than in justice. 13.5 13.10 13.15

That the medical profession has not so far been persuaded by Rawls and Daniels is not surprising. There is, in fact, no evidence that most people in the United States would be persuaded by Rawls if they confronted his argument, and considerable evidence that they would not be so persuaded. Sentiment backing the welfare state (insofar as it is backed) in the United States is predominantly humanitarian rather than Rawlsian (Feldman and Steenbergen, 2001). And insofar as Rawls's argument as to what we would choose in the original position has been tested against actual preferences, Rawls's predictions have not been borne out. People imagining themselves to be designing a society do not choose Rawls's principles of justice; rather than seeking to maximize outcomes for the least advantaged, they overwhelmingly prefer a regime that would maximize the median income with a floor for the least advantaged (Frohlich and Oppenheimer, 1994). 13.20 13.25 13.30

I do not urge these objections to Daniels' account of fair equality of opportunity, positive rights, or egalitarian conceptions of social justice considered more generally as conclusive for physicians or anyone else. The point is that the content of norms of social justice are contestable and, in fact, vehemently contested. That being the case, it is improper to require of physicians adherence to a particular egalitarian strand of justice theory that is far from commanding consensus either in academic discussion or in American society more generally. To impose such a requirement as a condition of professional membership would be unjust—would be, in effect, imposing an ideological litmus test. Physicians can agree on the need for justice; they can rightly hold themselves and one another to standards of justice that bear on medical practice. But they ought not to foreclose reasonable disagreement among themselves over the nature of justice in society. 13.35 13.40 13.44

Copyedited by: VR

14.1

VII. THE VIRTUE OF SOCIAL JUSTICE IS BEYOND THE SCOPE OF MEDICAL EDUCATION AND TRAINING

So far I have suggested that social justice fits among virtues or ideals proper to citizenship, rather than among the more restrictive set of moral norms specific to professional work. And I have argued that the diversity of legitimate views of social justice militates against requiring physicians to hold any one such view. There are additional practical difficulties with viewing social justice as a core element of medical professionalism. One such difficulty is its obvious potential conflict with the physician obligation to advocate for the individual patient. That actions taken on behalf of a given patient's welfare may conflict with the priorities of society seems obvious. Given the likelihood of such conflict, introducing social justice as a professional norm seems perilously like an invitation to serve two masters, when only one can properly be served. Another important practical difficulty with social justice as a core element of medical professionalism is the impotence of medical education to inculcate this norm in trainees.

How far education may instill norms or virtues of any sort is, of course, debatable. Moral psychologists have been moving away from the cognitive developmental perspective according to which cognitive engagement with moral abstractions is likely to effect moral change. Habit and emotion are likely to be quite as important as cognition in the genesis and maintenance of moral responses. If this is the case, consideration of morality through study or classroom exercises will be insufficient to effect change in the already-formed moral personas of medical students. What may do so is initiation into a way of life, as occurs in the later stages of medical training, internship and residency. Medical teachers have some chance of instilling the norms of professional work at these points of trainee development, at least among those trainees receptive to them. They do so by exhibiting these norms in their own work and by tacitly inviting trainees to engage with them. If they are successful, trainees emerge from their years of tutelage on hospital wards not only with technical knowledge but with a given moral sensibility that informs the use of such knowledge. It is during residency that the abstractions of medical ethics either take form in the lives of trainees or remain in their minds (if they do) as impotent abstractions (Huddle, 2005).

Clinical teachers, if they do their job well, will communicate the norms of medical work to trainees. And trainees, if receptive, will come to be governed by these norms; they will learn to act in loco parentis to sick patients while respecting patient wishes regarding medical treatment; they will learn to respect patient confidentiality, not to take advantage of patients in their illness, and the other norms of medical work commonly set out in codes of medical ethics. As regards justice, they will learn not to invidiously discriminate among patients. They will not have been taught to offer uncompensated care except insofar as they are aware that their training institutions

Copyedited by: VR

offer such care. Although most (all?) academic centers offer uncompensated care to many patients, trainees do not have much time of their own to offer. Training in this regard can only set out an expectation for future practice. What of more general dispositions toward social justice? The virtue corresponding to Daniels' view would presumably involve a sense of solidarity with the disadvantaged and an affirmation of their medical needs resulting in a combination of advocacy at institutional and political levels and uncompensated medical work on behalf of the underserved.

Academic medical centers could convey such social justice dispositions only if the spirit and purpose of such institutions as experienced by trainees were decisively aimed at improving the lot of the medically underserved. Although that is clearly part of what academic medical centers do, it is not and ought not to be their predominant mission. Academic medical centers aid the underserved as part of a broader mission of teaching, research, and service for all. Clinical teachers do not focus on the needs of the underserved in preference to the medical needs of any other patient. It would be odd if they did, because doing so would subvert the norm of justice to which they hold themselves: of addressing medical needs without respect to who may be suffering from them. Whatever the patient mix to which trainees are exposed in training, they learn to meet the needs of everyone for whom they care without respect of persons. It may be that those clinicians valuing social justice as conceived by Daniels will be able to convey that value to trainees during particular training experiences that focus on the underserved. But medical training considered as a whole is and ought to be an apprenticeship in doctoring generally, not doctoring on behalf of a particular societal subgroup.

Even if academic institutions were to redirect themselves away from broader service to society in favor of service to the medically underserved, they would likely struggle to achieve egalitarian social justice dispositions in trainees. The kind of commitment to social change demanded by Daniels' social justice vision cannot be presumed among trainees and cannot be coerced. It cannot be presumed because students choosing to study medicine do not commit themselves to one among various tenable views of social justice; such a commitment is not constitutive of professional work and thus does not naturally form part of the study and practice of medicine. It cannot be coerced because students, like the rest of us, do not alter their moral beliefs and commitments by being told to do so. Their teachers hope that they will grow into the morality of medicine, to which they have committed themselves, during well-supervised training. They will not take on a controversial view of social justice, which has no organic connection to medical training, through well-meaning exhortation in the classroom—except for those who have it in themselves to respond to such exhortation before they reach the classroom. Any attempt to impose such a view amounts to indoctrination not of essential elements of medical

Copyedited by: VR

16.1 morality, for which students have signed on, but of a civic morality without essential connection to medicine for which students have emphatically not signed on.

Academic institutions, in the course of serving the medically indigent, 16.5 can and should provide opportunities for physicians who wish to further an egalitarian vision of social justice. Trainees persuaded by Daniels' vision will seek immersion in medical and political effort on behalf of the disadvantaged. Some proportion of medical trainees have always been drawn toward such efforts and will find their way toward experiences of this sort, 16.10 often leading to careers in public health, health policy, or medicine practiced among the underserved. Such trainees choose praiseworthy careers; but, of course, careers aimed in other directions are also legitimate. Pathways toward such specific careers must remain options during the later stages of training rather than compulsory at early stages. Such experiences are suited 16.15 to the later stages of training because learning how to doctor generally must precede doctoring on behalf of particular groups of patients. They must remain optional rather than compulsory, because educational efforts aimed at all trainees must be focused on teaching them to be doctors for everybody.

16.20

VIII. CONCLUSION

The commitments of medical professionalism have traditionally included 16.25 justice concerns, but not the social justice presently called for by many for inclusion among professional norms. I have suggested that the case for social justice as a core element of medical professionalism has not been made. The commitments to justice that emerge in professional work do not imply any particular position on social justice, let alone the position of 16.30 egalitarian liberal social justice theorists. That being the case, the justice to which physicians must commit themselves as physicians should be limited to justice in professional work—which I have elaborated as treating like patients alike according to medical need. Physicians should also commit themselves to offering uncompensated care, but this commitment need not 16.35 be conceived as a matter of justice. Statements and codes of medical ethics should limit their pronouncements on justice to treating like patients alike. Physicians do have obligations to society, which gives them a monopoly of practice, pays for their training, and reimburses much of the medical care they provide. The most important such obligation is to practice competently 16.40 and ethically within the systems of practice extant and permitted in the society of which they are members. The medical profession also owes society its best advice on matters of health policy. That suggests that some but not all physicians ought to engage with health policy matters and be prepared to advise our government. The medical profession will inevitably be 16.44

Copyedited by: VR

involved in politics, as important professions (and other occupations) are in Western democracies. Its political voice will inevitably reflect a combination of public-spiritedness and self-interest. We may hope that public-spiritedness predominates, but some admixture of self-interest in our political expression is neither avoidable nor improper.

Insofar as advocacy is public spirited, it is, of course, admirable. Physicians exercising their political skills on behalf, say, of the medically underserved do society an important service. We in the United States collectively agree that making health care available to those who do not have it is a moral duty, but we have been unable to agree on the means of achieving that end at an acceptable cost. Resolving this impasse is clearly important for our moral and material welfare as a society. Physicians are well placed to grasp both the needs of the underserved and the practicality of various ways of meeting those needs. There are likely few better ways for physicians to display allegiance to norms of civic participation than by intelligent political action on behalf of the medically underserved. As laudable as such action is, it ought not to be construed as the necessary response to norms of professional work. The moral imperative to meet the needs of the medically underserved is a civic imperative, not a specifically professional one, as I have argued. Although it is plausible to suppose that some level of action to further the good of society is required of all citizens, we in medicine ought not to set that bar at a level requiring compulsory political advocacy of all physicians. To do so is, first, to confuse our professional with our civic responsibilities and then to specify the latter in a manner which our professional status gives us no legitimate authority to do. We simply do not have adequate warrant for declaring that all physicians must be neorepublican civic humanists.[2]

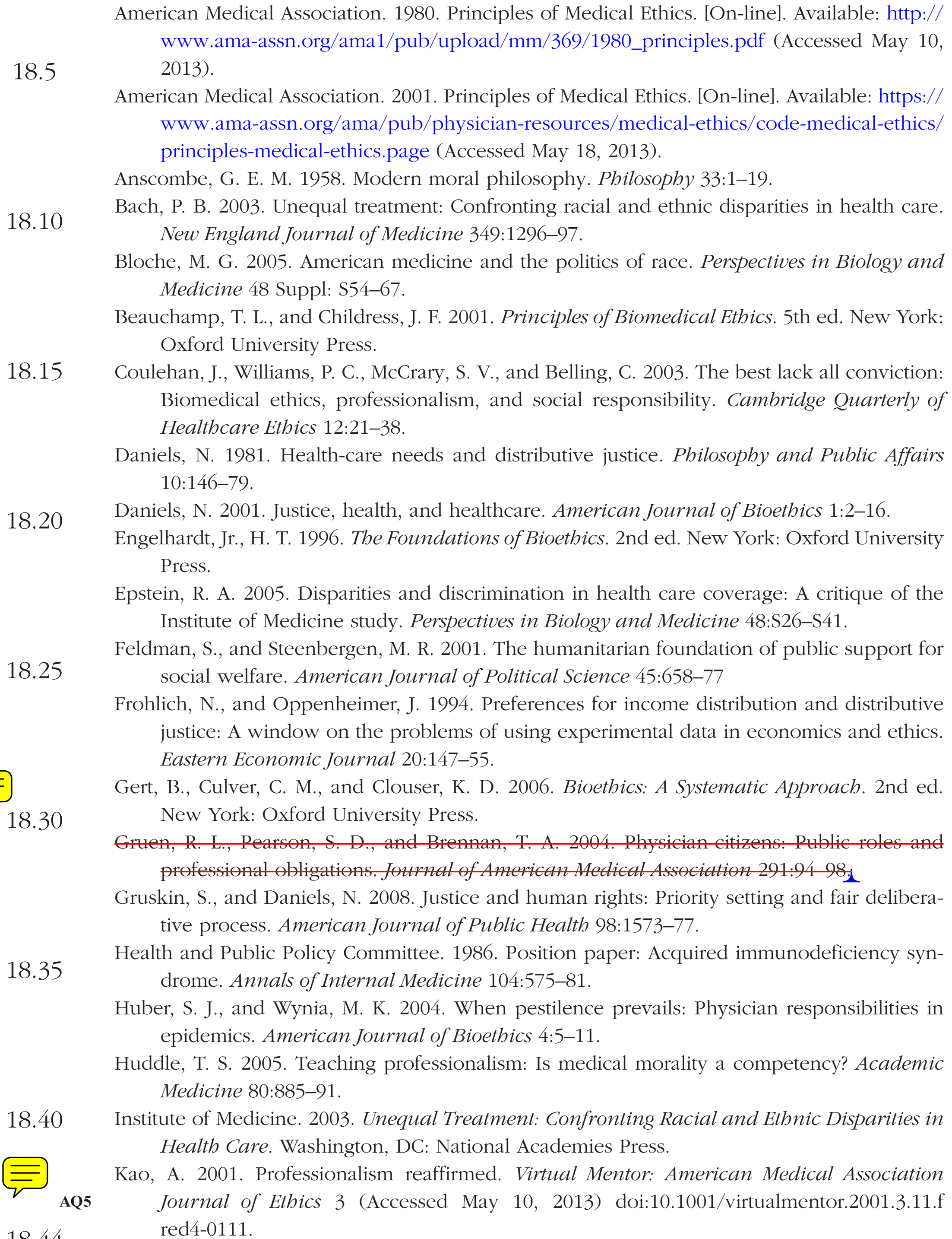
Any such attempt to diffuse professional ethics into realms where they do not belong can only dilute the necessary store of moral energy we must have for adhering to actual professional norms. Society rightly demands our advice; it can make do without our political advocacy but not without our skilled professional work conscientiously carried out. That is where our moral energy should be focused; that is what our academic institutions should enable and encourage; and that is the sphere of action with which codes of professional ethics should concern themselves.

NOTES

1. Or, rather, made. Daniels has recently refined his position on a right to health care to deal with its underdetermination of allocation decisions in conditions of scarcity. See Gruskin and Daniels, 2008. The medical professionalism literature as regards social justice has not, in general, specifically addressed this difficulty.

2. Civic humanism demands of citizens active participation in government; neorepublicanism denies that freedom from interference is sufficient freedom for citizens. On civic humanism, see Moulakis, 2011. On neorepublicanism, see Lovett and Petit, 2009.

Copyedited by: VR



REFERENCES

American Medical Association. 1980. Principles of Medical Ethics. [On-line]. Available: http://www.ama-assn.org/ama1/pub/upload/mm/369/1980_principles.pdf (Accessed May 10, 2013).

American Medical Association. 2001. Principles of Medical Ethics. [On-line]. Available: https://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.page (Accessed May 18, 2013).

Anscombe, G. E. M. 1958. Modern moral philosophy. *Philosophy* 33:1–19.

Bach, P. B. 2003. Unequal treatment: Confronting racial and ethnic disparities in health care. *New England Journal of Medicine* 349:1296–97.

Bloche, M. G. 2005. American medicine and the politics of race. *Perspectives in Biology and Medicine* 48 Suppl: S54–67.

Beauchamp, T. L., and Childress, J. F. 2001. *Principles of Biomedical Ethics*. 5th ed. New York: Oxford University Press.

Coulehan, J., Williams, P. C., McCrary, S. V., and Belling, C. 2003. The best lack all conviction: Biomedical ethics, professionalism, and social responsibility. *Cambridge Quarterly of Healthcare Ethics* 12:21–38.

Daniels, N. 1981. Health-care needs and distributive justice. *Philosophy and Public Affairs* 10:146–79.

Daniels, N. 2001. Justice, health, and healthcare. *American Journal of Bioethics* 1:2–16.

Engelhardt, Jr., H. T. 1996. *The Foundations of Bioethics*. 2nd ed. New York: Oxford University Press.

Epstein, R. A. 2005. Disparities and discrimination in health care coverage: A critique of the Institute of Medicine study. *Perspectives in Biology and Medicine* 48:S26–S41.

Feldman, S., and Steenbergen, M. R. 2001. The humanitarian foundation of public support for social welfare. *American Journal of Political Science* 45:658–77

Frohlich, N., and Oppenheimer, J. 1994. Preferences for income distribution and distributive justice: A window on the problems of using experimental data in economics and ethics. *Eastern Economic Journal* 20:147–55.

Gert, B., Culver, C. M., and Clouser, K. D. 2006. *Bioethics: A Systematic Approach*. 2nd ed. New York: Oxford University Press.

~~Gruen, R. L., Pearson, S. D., and Brennan, T. A. 2004. Physician citizens: Public roles and professional obligations. *Journal of American Medical Association* 291:94–98.~~

Gruskin, S., and Daniels, N. 2008. Justice and human rights: Priority setting and fair deliberative process. *American Journal of Public Health* 98:1573–77.

Health and Public Policy Committee. 1986. Position paper: Acquired immunodeficiency syndrome. *Annals of Internal Medicine* 104:575–81.

Huber, S. J., and Wynia, M. K. 2004. When pestilence prevails: Physician responsibilities in epidemics. *American Journal of Bioethics* 4:5–11.

Huddle, T. S. 2005. Teaching professionalism: Is medical morality a competency? *Academic Medicine* 80:885–91.

Institute of Medicine. 2003. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: National Academies Press.

AQ5 Kao, A. 2001. Professionalism reaffirmed. *Virtual Mentor: American Medical Association Journal of Ethics* 3 (Accessed May 10, 2013) doi:10.1001/virtualmentor.2001.3.11.fred4-0111.

Copyedited by: VR

Lamont, J. 2004. Distributive justice. In *Handbook of Political Theory*, edited by G. F. Gaus and C. Kukuthas, 1211–29. New York: Sage.

Lovett, F., and Petit, P. 2009. Neorepublicanism: A normative and institutional research program. *Annual Review of Political Science* 12:11–29.

Medical Professionalism Project. 2002. Medical professionalism in the new millennium: A physicians' charter. *Lancet* 359:520–22.

Miller, D. 1999. *Principles of Social Justice*. Cambridge: Harvard University Press.

———. 2002. Two ways to think about justice. *Politics Philosophy & Economics* 1:5–28.

Moulakis, A. 2011. Civic humanism. *Stanford Encyclopedia of Philosophy* [On-line]. Available: http://plato.stanford.edu/entries/humanism-civic/ (Accessed May 10, 2013).

O'Neill, O. 2005. The dark side of human rights. *International Affairs* 81:427–39.

Pellegrino, E. D. 1973. Toward an expanded medical ethics: The Hippocratic ethic revisited. In *Hippocrates Revisited*, edited by R. Bulger, 133–147. Cypress, CA: Medcom Press.

Pellegrino, E. D. 2001. The internal morality of clinical medicine: A paradigm for the ethics of the helping and healing professions. *Journal of Medicine and Philosophy* 26:559–79.

Pellegrino, E. D. 2006. Toward a reconstruction of medical morality. *American Journal of Bioethics* 6:65–71.

Rawls, J. 2005. *A Theory of Justice*. New York: Belknap Press.

Rothman, D. 2000. Medical professionalism—Focusing on the real issues. *New England Journal of Medicine* 342:1284–86.

Sen, A. 2004. Elements of a theory of human rights. *Philosophy and Public Affairs* 32:315–56.

Taylor, C. 1993. Explanation and practical reason. In *The Quality of Life*, edited by M. C. Nussbaum and A. Sen. 208–231. New York: Oxford University Press.

Veatch, R. M. 1984. The Hippocratic ethic is dead. *New Physician* 48:41–2.

Vogler, C. 2006. Modern moral philosophy again: Isolating the promulgation problem. *Proceedings of the Aristotelian Society* 106:345–62.

Wagner, P., Hendrich, J., Moseley, G., and Hudson, V. 2007. Defining medical professionalism: A qualitative study. *Medical Education* 41:288–94.

Wear, D., and Kuczewski, M. G. 2004. The professionalism movement: Can we pause? *American Journal of Bioethics* 4:1–10.

19.1 19.5 19.10 19.15 19.20 19.25 19.30 19.35 19.40 19.44