The Ethical Responsibility of the Physician
A Judeo-Christian Perspective

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While a resident in psychiatry at a large metropolitan hospital, I was called to the Emergency floor one evening to see a Hispanic lady, who was reported to have an anxiety attack. I found the lady very distraught, frightened, and shaking all over. Since she could not understand English, I asked her in Spanish what was wrong. She told me she had been feeling upset after a quarrel with her daughter-in-law and had come to the hospital to talk with someone. However, when she arrived at the hospital, the doctor, unable to communicate with her, assumed she had taken an overdose of drugs. He forced a rubber tube down her throat and pumped out her stomach. In desperation, she told me: "I feel worse now than before I came to the hospital."

This is an example of how traditional health care delivery has been a one-way process, from health care provider (physician) to consumer (patient). This has been so for planning, treatment, and research. In many ways, the consumer has had no choice but to shut his mouth and be thankful for the crumbs of blessing, good or bad, falling from the table of the all-powerful health care provider. This situation has led to blatant abuses of the doctor–patient relationship: the unethical Tuskegee syphilitic study, experiments with the injection of potentially lethal hepatitis virus into mentally retarded residents at Willowbrook, and deplorable care of the elderly and other underprivileged groups, to name but a few (1). The underlying dynamic here is that of power (provider) versus powerlessness (consumer). Thus, in such a situation, the quality of health care is directly proportional to one's power base, e.g., intelligence, financial status, race, political support, awareness of system, etc. However, health care delivery, like any other psychologically sound interpersonal relationship, must be a two-way process with the provider and consumer working together in a constructive and trusting relationship. But this psychological awareness is not enough. The two-way relationship must be buttressed with a mature ethical or moral framework which engenders respect for the human rights and personhood of the provider and the consumer. According to Ivan Illich (2), "Medicine is a moral enterprise and, therefore, inevitably gives content to good and evil: In every society, medicine like law and religion, defines what is normal, proper and desirable. Medicine has authority to label one man's complaint a legitimate illness, to declare a second man sick—though he himself does not complain—and to refuse a third social recognition of his pain, his disability and even his death!

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The need for such an ethical perspective is ever more accentuated by the development of new biomedical technologies. The availability of organ transplants, genetic manipulation, psychosurgery, and prenatal diagnosis calls for our wisest judgments. Even the opportunity to achieve the ultimate in medical technology becomes destructive without a moral plumbline to safeguard the rights of the individual, e.g., medical experimentation in Nazi Germany (3).

How then can this ethical perspective be introduced and maintained in medicine? In order to examine the ethical responsibility of the physician, at least five areas must be considered: the facts, the theological basis, the moral reasoning, loyalties, and implementation.

THE FACTS

Good ethics depend on good data. Therefore, the primary responsibility of the physician should be to master the body of available medical knowledge in order to be technically competent.

Once the physician has committed himself to this task of seeking the facts at all costs, how he views these facts is of utmost importance.

Firth’s “Ideal Observer” theory offers the physician an excellent model to follow in the acquisition and utilization of medical knowledge. According to Firth, the Ideal observer is omniscient, omnipercipient, disinterested, and dispassionate, consistent, and otherwise normal (4).

In striving toward omniscience, the physician should be committed to improving his knowledge through courses, consultation, practice, and research. Yet, medical expertise alone is not enough. He should acquaint himself with other relevant fields, seeking to gain an understanding of the ethical, legal, social, and political influences upon his work. And, if need be, he should always be willing to request consultation from experts in these fields. However, this is more easily said than done. The demand for services, family pressures, and other interests compete for the physician’s time, making it very difficult to keep up with the rapidly advancing frontiers of medical knowledge. Nevertheless, more can be done by medical institutions to make it possible for physicians to take more meaningful educational leaves.

To approach omnipercipience, the physician should try to understand how his work is perceived by and affects others. For example, he should take into account the patient’s perspective of the illness in setting goals for treatment, consider the patient’s view of care received when evaluating a mental health program, or give a pregnant woman needing prenatal diagnosis the opportunity to talk with another person who has undergone the same procedure.

The dynamic principle here is “empathic caring,” a caring which results from identifying with another and then treating him as you, yourself, would want to be treated. In essence, it is the Principle of Reciprocity, better known as the Golden Rule (5), the true basis for ethical responsibility in the doctor–patient relationship.

Putting the Principle of Reciprocity into practice, however, demands a marked degree of psychological maturity; it involves the ability to feel with, to imagine vividly the hurt of others, and a willingness to be open and tolerant. I don’t want to imply that all physicians should have psychotherapy to improve their personality; however, I do feel that the doctor should be honest in asking himself if he can relate to his patients. If he can’t, then I do suggest involvement in some form of therapy or learning experience to enhance his ability to empathize with the persons he serves. For example, a group of colleagues and myself at the Boston City Hospital realized our inability to communicate effectively with the numerous community groups served by
the hospital, so we set up mutual educational seminars for doctors and consumers. This was a challenging learning experience for both groups and had a positive effect on the overall delivery of health care.

The Ideal Observer is also disinterestedly interested and dispassionately passionate. But how can the physician deny particular interests or passions in order to be interested or passionate toward the whole? I suggest that in making very difficult medical decisions, a relative state of disinterestedness and dispassateness can be achieved by involving a multidisciplinary review committee in the decision-making process. Thus, particular interests or passions are diluted and balanced by those who hold opposing views or perspectives. The best example of such a process is the legal jury system. Have we not reached the time when the ethical dilemmas in medicine require a medical jury? Is it any more serious for a court of law to sentence a man to life imprisonment than for a surgeon to irreversibly change a man's behavior by implanting electrodes in his brain?

I have organized multidisciplinary committees to review the surgical treatment of temporal lobe epilepsy (6) programs for mentally retarded persons and to evaluate State and Federal mental health services. Although the committee format is not ideal, it does offer broader-based advocacy and the chance of better-informed consent for the client. It also gives support to the provider and the client, and simultaneously it is an excellent mutual educational process. This engenders an atmosphere of trust and openness within the doctor-patient relationship, thus leading to the delivery of more just and humane medical care (6).

Consistency in all aspects of a physician's work does not mean rigid, inflexible attitude but, rather, implies a sincere commitment to the fair treatment of all individuals. The doctor is obligated to give dependable, high-quality health care to all his patients, regardless of their own familiarity with medical procedures or ability to pay.

Finally, the Ideal Observer should be otherwise "normal." The doctor is just a normal person, with limited knowledge and expertise. As a result, he is periodically subject to failure through ignorance, oversight, or incompetence. This awareness of limitation and possible failure should not cause him to retreat but should underscore his responsibility to recognize his limitations and allow his work to be examined in an atmosphere of openness and consultation with others.

THEOLOGICAL BASIS

Good medicine, however, involves more than accurate information and technical competence. Facts and technical knowledge must be related to the human ethical perspective in order to serve the best interests of the patient. According to Arieti (7), "Values always accompany and give special psychological significance to facts and that when we deprive facts of their value, we fabricate artifacts which have no reality in human psychology. An individual may suspend his value judgment when he wants to examine a fact from a specific point of view, but then the ethical content has to be re-established if the fact is to have human significance. If we remove the ethical dimension, we reduce man to subhuman animal."

Therefore, the physician must be cognizant of his personal ethical value system and its relation to those he serves. What one believes about the nature of man exerts a subtle but controlling influence on attitudes, behavior, and treatment of individuals. Eisenberg (8) says that: "What we believe of men affects the behavior of men for it determines what each expects from each other. Theories of education, of political science and economics and the very policies of government are based on implied concepts of the nature of man."
Thus the physician cannot apply the Principle of Reciprocity (the Golden Rule) in his work if he believes that other men don’t deserve the same dignity and respect he, himself, does. For example, during an evaluation of a community mental health center, a psychiatrist commented that “even though the state hospital environment is sub-standard, it is suitable for chronic mentally ill patients because they don’t need anything better.” This value system must affect his attitude and treatment of chronic patients and, hence, his commitment to mental health reform.

For the most part, Western ethics are based on the Judeo-Christian tradition which, at its heart, claims that man is made in the image of God (9). This imago dei is the basis for personhood, dignity, and basic human rights. This quality of inestimable value of the individual enhances personal meaning, interpersonal relationships, and human community. The Christian faith further teaches that God’s sacrificial love, manifested through the self-giving life, atoning death, and triumphant resurrection of Jesus Christ, reaffirms the uniqueness and ultimate worth of each individual person (10–12). It is this reverence for man that Niebuhr says is necessary for meaningful social reform (13). It is this common fatherhood of God and brotherhood of man which caused Jesus to say (14): “What ye have done with one of the least of these my brothers, ye have done it unto me.”

Thus, the physician with Judeo-Christian convictions should see all individuals, regardless of age, race, class, or illness as persons first, deserving the utmost respect and concern. For example, the individual with schizophrenia should not be seen merely as a “schizophrenic” but as a person first, who has problems in mental functioning. And, likewise, doctors are persons first, with problems in other areas.

This concept first gripped me while working at a drug addiction clinic in East Boston. At times, it seemed almost impossible to cope with the threat of violence, the frustration of treatment failures, and the anxiety about my role as a psychiatrist in that setting. However, one day, while talking with a patient about his drug habit, I realized that I had not previously seen him as a person in his own right but only as a “drug addict.” It dawned on me that he wanted to be loved, respected, and cared for as I did. In my concern about his drug addiction, I had stressed his pathology and weaknesses and denied his positive assets and strengths. This resulted in blatant rejection of his personhood and hindered the development of a true therapeutic alliance. This realization revolutionized my work at the clinic.

Thus, the basis for the doctor–patient relationship is our common God-given personhood, rather than our diverse problems. This is the meaning of Buber’s I–Thou relationship as opposed to the dehumanized I–it or subject–object interaction. This ability to see in each other the person, the shared human qualities which go deeper than our differences, is the essential ingredient in the formation of the therapeutic alliance between doctor and patient. Only then can the Principle of Reciprocity become a practical reality in our actually doing for others as we would have them do unto us. Is this not the basis for caring?

In addition, the moral responsibility inherent in the reciprocal, empathic, interpersonal relationship between physician and patient requires allegiance to other indispensible principles such as respect for person, trust, forgiveness, truth-telling, love, promise-keeping, justice, liberty, and noninjury. These principles are so germane to the human community that they may be called the constitutive imperatives, i.e., the underlying principles upon which all laws governing society are made.

Josen and Butler emphasize the importance of this concept (15): “Respect for individuals requires that every individual be treated in consideration of his uniqueness, equal to every other, and that special justification is required for interference with
their purposes, their privacy or their behavior. It implies sets of liberties, rights and duties and obligations, especially of promise-keeping and truth-telling."

Thus, the physician, in order to be true to the human ethical perspective in his work, must continually place himself in the position of the patient, feeling what the patient feels and then treating him as the physician himself would like to be treated. The ethical dynamic is that, if the services are not suitable for the physician or his family, then they are not suitable for the client. As a result, the moral imperative is that the doctor must be committed to a process of constructive change to make the services available to the patient acceptable to himself or his family as well.

I was particularly challenged by this during the illness of my wife, while I was a resident. I was apprehensive about having her admitted to my hospital because I did not feel that the facilities were good enough. My dilemma was that if the facilities were not good enough for her, then they should not be acceptable for my patients. I realized that the only way I could ethically continue to work at the hospital was to be involved in a process of organized political action to improve the conditions at the hospital. This led to the formation of a coalition of providers and consumers who were instrumental in getting the mayor and trustees of the hospital to upgrade the facilities at the hospital.

**MORAL REASONING**

The moral reasoning underlying any process always affects the way persons are treated. The physician must therefore examine the types of moral reasoning operating in his work. There are many different forms of moral reasoning ranging from the Ethical Egoism of Kohlberg's Stage I to the more sophisticated Formalism of Stage VI (16). Often, however, the physician is confronted by two major conflicting types: Social Utility versus the Equal Value view of life.

Though the concept of social Utility comes in many varieties, its essence can be summed up as promoting the greatest good for the greatest number or the most powerful, i.e., those who define utility. Though appealing for the majority or the most powerful, it offers nothing for those who are in the minority or powerless. This may help explain the atrocities inflicted by biomedical technology on certain disadvantaged groups, such as the mentally ill, the mentally retarded, and the racially outcast, those assumed to be expendable for the greater good of humanity.

A frequent corollary of this concept is the inherent fallacious assumption that only life of a certain quality has worth. Thus, there is a tendency to define personhood on the basis of one's relative social utility. As a result, whenever the utility/disutility ratio is upset, one's worth as a person becomes less. For example, becoming mentally ill reduces utility and, as a result, the person becomes subject to a barrage of indignities and loss of human rights, manifested by dehumanizing conditions, lack of treatment, inadequate rehabilitation, and job discrimination.

Under the euphemism of the public good, a utilitarian merit view of justice denies positive presumption, due process, and equality. This strains the moral fiber of the society itself and undermines the meaning of those indispensable humanizing qualities of love, compassion, justice, and liberty for all its members. Eventually, this leads to a society, or better still, a "non-society," which is insensitive to the needs of its weak. Thus, only the powerful are strong, and they are strong only as long as they have power.

In contrast, the Equal Value view of life affirms that all individuals, regardless of their utility/disutility ratio, are persons who have an equal claim to dignity, respect, and human rights. Thus, all persons have utility, but utility must never define person-
hood and the right to life, liberty, and good in the world. The physically ill, mentally ill, and retarded, the racial minority, and the elderly are persons deserving equal treatment, regardless of their power base in society. Justice demands an equal consideration of each person's claim, regardless of the person or his situation. Thus, the powerful in society must share their power base with those who have none, making advantages for even those who are most disadvantaged.

In times of budget cuts and the politicalization of medical care, the physician has an even greater responsibility to the public good. He will be pressured to use his expertise to satisfy the whims and fancies of those in power rather than represent the interests of those in need. It seems so easy to adapt to a utilitarian philosophy of the greatest good for the greatest number, or the most powerful. Yet, in reality, we would do well to remember that the disadvantaged are an integral part of human society. They are a part of us and we are a part of them. The way we treat them is a direct reflection of the quality of existence we espouse. Therefore, the physician must be a guardian of the human ethical dynamic in society. This can only be done effectively if the moral reasoning involved in his work leads to the enhancement of the dignity of all persons, especially those in need.

LOYALTIES

Our loyalties dictate the ultimate ends we serve in our work. "For where your treasure is, there will your heart also be" (17). The physician must face the question: "To whom and to what am I ultimately responsible?" He must examine where his basic loyalties lie in relationship to his means and ends.

For the Christian, the true goal of life for all individuals is to glorify God and experience the meaning and fulfillment of their God-given personhood, dignity, and human rights. This demands a strong commitment because all else in life must function as a means to that end.

Therefore, the Christian physician should see his medical practice as a means to enhance the dignity and human rights of his patients. This involves not only helping the individual to appreciate his own worth, autonomy, and responsibility but simultaneously demands a commitment to institute more equitable justice structures in the surrounding society. This is the quintessential characteristic of community health care in its ideal form.

This perspective is of utmost importance, for, whenever a means, even with the best intentions, becomes an end in itself, persons are dehumanized, even destroyed. Whenever medical practice becomes an end in itself, a vicious cycle is set up and the human ethical perspective is lost. For example, Hitler had technically competent physicians, but since their loyalties were to medical science for the super race rather than the individual person, their medical practice led to the destruction of human life rather than respect for its dignity.

A more contemporary example is the recent trend of deinstitutionalization of chronically mentally ill patients. As a State Inspector of Mental Health, I have found evidence, in some instances, that deinstitutionalization, an excellent means to achieve the end of good patient care for some persons, has become an end in itself. The result is that patients are mistreated by being discharged en masse to communities to live in deplorable conditions, without proper after-care.

It behooves the responsible physician to examine his motivation and loyalties constantly in all aspects of his work. This is especially important in light of new developments in biomedical technology. Coming at a time when values are in crisis, the family disintegrating, the economy depressed, and the national spirit all but
crushed, it is difficult to maintain an ethical perspective of ends and means. As a result, there is a subtle temptation for society to see technological achievement as a means of salvation. However, for the physician with Christian convictions, biomedical technology, whether it be life-sustaining machinery, psychosurgery, or prenatal diagnosis, is only a tool to be used as a means to enhance the meaning of the personhood and the dignity of individuals. And whenever that tool, regardless of how important, contradicts this perspective, it must be considered obsolete or placed under certain ethical restraints. Our practice must always reflect the principle that technology was made for man and not man for technology.

Loyalty to this perspective may also mean the refusal to use certain medical procedures because of insufficient knowledge or advising a patient to see another doctor who is more skilled in a particular area. This must not be seen as failure but a sign of the doctor's commitment to act in the patient's best interests always.

IMPLEMENTATION

In the area of implementation, we must tread cautiously. In order to clarify his convictions and motivation, the doctor in practice should repeatedly ask himself: Am I treating this patient as I would want to be treated? If not, why? Can I appreciate the personhood and dignity of this patient, even though he is disabled, elderly, retarded, or chronically mentally ill? How can my interaction with this patient enhance his meaning and individuality? Have I given the patient sufficient information in order to have proper informed consent for this procedure? Would I have the same procedure carried out on myself or a member of my family? Can I universalize my actions; i.e., what would happen if everyone acted as I do?

From the ethical perspective, action and motivation are inseparable. The requirement for both is justice, mercy, and humility. Micah, the Hebrew prophet, describes it well (18): "What, O man, does the Lord require of thee but to do justice, love mercy and walk humbly with God." This provides an excellent guide for the physician when considering the ethical responsibility of his work.

Do justice. Doing justice involves treating all persons fairly with the highest standard of technical excellence. It also implies being active in seeking to bring about meaningful societal change to produce conditions more conducive to better health. For example, while a psychiatric resident at the Boston City Hospital, I was called upon at two o'clock in the morning to see a lady on the Emergency floor who was suffering from an anxiety attack. She complained that two large rats had crawled over her while she was dosing off to sleep. When I informed the nurse of the patient's problem, the nurse started screaming as well. (I was confused as to who should be treated first!) This lady had tried on numerous occasions to get the landlord to do something about the rats, but to no avail. In essence, this lady's anxiety attack was a cry for better conditions, for "rat therapy"! Tactful pressure on the landlord the following day led to the elimination of the rats. Thus, the doctor must be willing to share his power base with those who are in need. For even within the microcosm of the doctor-patient relationship one can be an exponent for justice in the macrocosm of society as a whole.

Similarly, as a clinical evaluator of State mental health programs, my religious convictions obligate me to gather data with one goal in mind: the improvement of patient care. For without this goal, evaluation can be a bureaucratic defense against facing the problem and instigating the appropriate action or reform. For example, there is no need for an extensive evaluation of care on a ward where only one staff member is responsible for 40 severely mentally retarded persons who are wallowing
in urine. The only ethically acceptable response in this situation is action: more funds, staff, or better environment.

**Love mercy.** The physician should be merciful and compassionate, treating others as he would want to be treated. This compassion demands action beyond the purely technical aspects of medical practice. It is a commitment to caring, empathy, identification with the patient, and not to the extent of being so emotionally involved as to become ineffective, but to develop a sense of closeness and trust so that throughout the treatment process the patient is aware of his meaning, dignity, and human rights. For example, this may lead a physician to learn a foreign language in order to relate better to his patients. In my experience, familiarity with the patient’s language and culture proved a major healing factor in a large metropolitan psychiatric clinic serving many Hispanic patients.

**Walking humbly with God.** Because the dilemmas are many, the solutions few, and the knowledge limited, the physician has ample cause to be humble. He should willingly plead ignorance or admit failure and be open to seek consultation from higher or better authority.

However, walking humbly with God means acknowledging His presence, love, and wisdom which transcend human frailty and limitation. This awareness of God’s transcendence enables the physician to face the innumerable problems and challenges of his practice with renewed determination and unflinching commitment. For he knows that with this comes the joy of ultimate victory: the realization that good has overcome evil, justice injustice, and hope despair. Therefore, his aim is not only to be successful but above all to be faithful to the task to which he has been called.

“For this is the victory that overcomes the world—our faith” (19).

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