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SOCIAL ETHICS, THE PHILOSOPHY OF MEDICINE, AND PROFESSIONAL RESPONSIBILITY

ABSTRACT. The social ethics of medicine is the study and ethical analysis of social structures which impact on the provision of health care by physicians. There are many such social structures. Not all these structures are responsive to the influence of physicians as health professionals. But some social structures which impact on health care are prompted by or supported by important preconceptions of medical practice. In this article, three such elements of the philosophy of medicine are examined in terms of the negative impact on health care of the social structures to which they contribute. The responsibilities of the medical profession and of individual physicians to work to change these social structures are then examined in the light of a theory of profession.

Key words: Profession, Philosophy of medicine, Ethics, Social ethics, Professional obligations, Professional ethics.

INTRODUCTION

The social ethics of medicine is the examination of the social structures which impact on and positively and negatively condition the provision of health care by physicians. There are many such structures; in this essay, however, I will examine only a sampling of them. My primary concern is to ask whether physicians should be considered, and should consider themselves, responsible for those social structures, which impact negatively on medicine. Is it proper to say that physicians have obligations to work for changes in social structures which affect health care negatively? There are two brief, simple answers to this question, and then a longer, more complicated answer which it is the task of this essay to attempt.

The quick, simple answers to this question are, predictably, yes and no. Yes, of course physicians are responsible for the social structures which affect medical practice. They are responsible for social structures in the same way that all adult citizens of a society like ours are responsible. They have the vote; they have numerous avenues available to them for public speech and action. If the society has certain structures, it is because the members of that society have created them or supported them by tolerating them or, at a minimum, by failing to work against them. Thus physicians are responsible and have the corresponding obligations.

And no, physicians are not responsible for the structures of our society which impact on health care. For, in a huge society like ours, few individuals have any direct impact on social change or its outcomes. Nor can the indirect connection

Theoretical Medicine 6 (1985), 281–294. 0167–9902/85.10

mentioned above be considered the basis of significant responsibility or obligation. For a citizen who refrains from challenging some actual structure often rightly perceives himself or herself as incapable of significant action alone; and the burdens of initiating significant collective action are often so great that they may be reasonably thought to outweigh whatever obligation the individual might have to work for change. So the physician is not responsible for changing the social structures which negatively impact on health care.

Both of these answers speak truly in some measure, but neither of them attempts to look in depth at how social structures are affected by professional groups. In order to do this, I shall begin by examining the nature of a profession.

In the second section I will look at three examples of underlying features of professional medical practice which have helped to create or which continue to support social structures which impact negatively on health care. The study of such underlying features, or preconceptions, of medical practice is the philosophy of medicine, and one aim of this essay is to show how the study of such preconceptions is an essential component of the social ethics of medicine. The third section will discuss strategies for changing social structures which negatively affect health care and individual physicians' obligations to participate in such strategies.

PROFESSION AND RESPONSIBILITY

Until recently, sociologists' descriptions have stressed four characteristics of a profession. First, a profession involves extensive formal education beyond the ordinary. The reason for this special training derives from the second characteristic, namely that each profession possesses knowledge and experience which constitute an expertise not accessible to the ordinary person.[1] Third, the members of the profession adhere to a commitment to serve their clients' interests, and not merely their own, in the use of this expertise. Finally, the clients of a profession respond to this expertise and this commitment with trust, entrusting to the members of the profession important decisions affecting their wellbeing with confidence that the professionals will indeed serve the clients' interests and not merely their own.

The basis of professional obligation in this account of a profession is the professional's making a *commitment* to act in a certain way by becoming a member of the profession. The prospective professional has the option to join or not, that is, to adopt the established norms and standards which indicate how to act as a member of the profession, or not. Thus the basis of a professional's responsibilities and obligations is the choice to join, an act which is not directly dependent on any actions of the larger community. The profession in turn

shapes itself through the activities of its members. Those outside the profession, the profession's clients, have no role in shaping the profession's own norms or standards. They may support the profession or not with their feet, by using or choosing not to use its services. But the dominant relationship between them and the norms which guide both individual professionals and the profession as a whole must simply be one of trust which accepts the profession (or not) as it defines itself and as it determines its responsibilities.

More recently a number of sociologists and other social theorists have proposed an account of profession which supplements the description just given and deepens it by explaining the links between expertise, commitment, and trust which the first account merely posits.[2] While the word may seem odd at first, still the added dimension which these more recent accounts of profession have incorporated can be best expressed in the word *power*.

First, the expertise of the professions concerns matters of the highest importance: life, death, relief of pain, our basic physical and civil capacities to function, and the like. These matters are not optional; they concern underlying conditions which must be fulfilled if we are to pursue any of our other goals. Therefore control over crucial information about them, and over the experiential training on which correct application of this information depends, constitutes an important form of power, both in the individual encounter between client and professional and in the relationship between each profession and the community at large. The client frequently hands over extensive decision-making authority to the professional, the power to effect great good or ill in his or her life. The conscientious professional will not use this power *as* power over the client. But professional expertise always includes the possibility of its use in other ways. This is an important feature of all professional expertise.

Similarly at the macro-level, professions in our society control access to their respective forms of expertise. Each controls the training programs in which information and the experience necessary for the practical application of that information are communicated to new members of the profession. Each has been empowered to have the final say in determining who will or will not be trained and who has and who has not acquired that expertise. Consequently the profession as a whole possesses power in relation to important life values of the larger community. The profession may again conscientiously refuse to use this power *as* power. But the possibility remains because of the nature of professional expertise, and the larger community, if it is thoughtful, knows this.

Secondly and as a consequence, although the larger community sees the value of placing this power in the hands of a small group of individuals, the community also seeks assurances that this power will not be used in any inappropriate way. So the community seeks to establish social structures that

make proper use of this power more likely. The chief structure that has been developed to this end is the notion of profession itself.

Consider the level of suspicion which we habitually entertain towards politicians. We give them power, but we watch them closely, using periodic reelection, a free press, and many other structures to keep their use of power in check. Yet regarding the professions we employ few such strategies, employing instead the notion of profession and professional obligation. Each of the professions and each of their members makes a commitment to employ the power of their expertise well; and the concept of profession and the real loyalties it represents serve to bind both individual and group to live according to this commitment. Given our usual, and justified, distrust of holders of power, this is a very unusual relationship.

But, thirdly, this means that professions do not shape themselves. They are the product of a complex interaction between possessors of a particular expertise and the society at large. The larger society permits crucial forms of expertise to be possessed by a small group who are in turn empowered, and even protected in that power, to govern how and to what ends that expertise shall be used. It is the larger community and the possessors of expertise together, not the latter alone, who define each profession and its responsibilities and obligations in such a way that it can be trusted to use its power properly. This is not first of all an activity between individual clients and professionals, nor an activity merely of those who make up a profession. It is first of all an activity, not fully conscious or deliberate perhaps, but profoundly social, of the whole community in relation to those who possess certain forms of expertise. An upshot of this is that professions are to be seen as constantly interacting with the larger community. The members of a profession must be in constant dialogue with the larger community regarding the profession's specific role in relation to the community's life values and the changing circumstances of their realization.[3]

PHILOSOPHY OF MEDICINE

Philosophy of Medicine refers to efforts to articulate as clearly as possible the underlying presuppositions, both as to content and as to aims, of medical practice. I shall not attempt here even a brief summary of this field.[4] I shall concern myself with just three features of medical practice which are closely linked with social structures which impact significantly on health care in our society. The three features of medicine[5] to be examined are: (1) *its focus on crisis intervention*; (2) *its focus on the physiological-biochemical aspects of disease and health*; and (3) *and its focus on the one-to-one relationship of patient and the individual physician.*

It is a commonplace that the United States' health care system generally, and especially the role played within it by physicians, is much more strongly focused on crisis intervention than on prevention of disease or accidents, or on health maintenance. It is widely recognized that advances in prevention and health maintenance, including for example, innoculations, public health efforts for sanitation, and education for sound nutrition, are at least as responsible for advances in health over the last century as advances in our ability to treat already existing conditions of disease and injury. Yet medical school and residency training programs and the actual practice of most medical specialities are strongly oriented in the direction of crisis-intervention care.

To be sure, most physicians actively recommend prevention and health maintenance, and some medical specialties, like pediatrics and obstetrics-gynecology, place these among the highest goals of their practice. But the most important message communicated to the community at large about medicine is that prevention and health maintenance are not what this profession is primarily about. Its predominant task is the treatment of already existing conditions of disease and injury.

It is also true that other health care professions, especially nursing, dentistry, and public health, have given prevention and health maintenance a much more prominent place in their practice. But it is medicine which is the dominant shaper of the larger community's understanding of health care in our society. So it is medicine's primary focus on crisis-intervention which colors the whole community's most habitual perceptions about the nature of health care.[6]

The community's perception in turn shapes the community's actions. Because health care is conceived as crisis intervention, people do not generally seek professional assistance unless they believe that disease or injury is, or at least may be, already present. Their expectations are also shaped by this habit of mind. They expect the medical profession to become more and more skilled at stopping disease processes and rectifying injuries, even when prevention of the same injuries and diseases and the maintenance of the corresponding aspects of health would be far more efficient uses of resources. This bias in turn reinforces the profession's bias in favor of crisis-intervention, which further supports the community's bias, and so on.

To be sure, there are other forces which support and reinforce this bias on both sides. For example, there are biases within our American culture which favor immediate action and immediate gratification over long-term action and delayed gratification, and which favor manipulation of the environment over its maintenance or its conservation by supporting its self-maintaining capacities. So the presupposition of contemporary medicine in favor of crisis-intervention cannot be wholly blamed for the habitual perceptions and patterns of action within the community at large that bring patients to the health care system

only when they have already fallen victim to injury or disease. But this feature of medicine has certainly helped to form and perpetuate this social structure.

This social structure of perceptions and patterns of action inhibits some of the most efficient forms of health care, particularly in an age of strained health care resources. It inhibits the provision of the best health care for those patients whose circumstances call for preventive or maintenance care, because members of the community so strongly presume that disease will be stopped and injuries rectified. It also inhibits the formation of the kind of physician-patient relationship most conducive to health by conceiving of the physician and the whole health care system as the responsible party, the one who provides health, and of the patient as its passive recipient.

For these and other reasons this social structure has a significant negative effect on health care in our community. Insofar as medicine, as a profession, is responsible for the existence and robustness of this social structure, the medical profession has an obligation to dialogue and to act in concert with the larger community to change it. This raises in turn a question about strategies for such change and about the obligations of the individual physician to participate in these strategies. I will address both of these issues in the third section. My next concern here is a second presupposition of contemporary medicine, its focus on physiological and biochemical, rather than psycho-social and environmental, causes of disease and health.

It is widely recognized by physicians that psycho-social and environmental factors play a powerful role in determining the prevalence of specific diseases and forms of injury in a population. They play a similar role in regard to an individual patient's abilities to respond to treatment, to ward off complications, and to deal with handicaps. Nevertheless these factors receive only token attention in most medical school and residency programs and, except in a few specialties like pediatrics and family medicine, play only a modest role in the actual practice of most physicians. The dominant focus in medicine is on the physiological and biochemical aspects of disease and illness.

Once again there are other health professions which give genuine emphasis to the role of psycho-social and environmental factors in relation to health, disease, and injury. But it is again the medical profession which chiefly shapes the larger community's perceptions regarding health and disease.

Here too there are cultural patterns which favor an emphasis on physiological and biochemical factors in both the lay and the medical communities. The point is not that medicine, as a profession, is solely responsible for this important social structure which impinges significantly on health care in our society. It is rather that medicine, as a profession, bears significant responsibility for the existence and importance of this structure and then to ask what sorts of obligations this responsibility implies.

A few examples must suffice to summarize the evidence that this social structure is not all for the good and therefore needs to be changed or modified. First, this way of perceiving health and health care affects health care in ways similar to the first social structure examined above. Because the layperson does not possess extensive knowledge of the physiology and biochemistry of disease and injury, an habitual perception of health and health care in these terms will remove the responsibility for health and disease from the layperson's shoulders to those of the health professional, especially the physician, who is most expert in physiological and biochemical categories. Thus the undesireable pattern mentioned earlier, in which responsibility for health, diseases, and recovery from injury are placed primarily on the physician and the health care system, rather than being born at least equally by the patient, and by his or her community and environment, is strongly reinforced by this social structure.

This structure also reinforces the pattern of emphasizing crisis-intervention, which is the chief activity of those expert in physiology and biochemistry, rather than the activities which the nonexpert could carry out on their own or with a little direction, including most prevention and health maintenance. Thus again this pattern supports important inefficiencies in health care at a time of lessening resources.

Moreover by de-emphasizing the role of the inexpert layperson, the dominant focus on physiological and biochemical aspects of health and health care also makes it harder for patients and their families to participate in important health care decisions. For it prompts these to be interpreted as matters of purely expert scientific judgment rather than complex value questions which are founded on scientific understanding, but require the patient's own values and priorities in the decision-making process. As the value dimension of difficult medical decisions becomes more evident to us, the negative consequences of this social structure become more and more obvious as well.

This social structure also inhibits cooperation between members of different health professions. With physiological and biochemical factors, emphasized by one profession, medicine, accepted as the dominant factors in health and health care, other health professions are placed in a subservient role, in spite of their evident expertise in matters which physicians generally respect and would rarely claim to have mastered. This hinders mutual understanding and cooperation between individuals and between professional groups, and produces not only friction, but a lower quality of health care for patients who depend on the blending of many professions' expertise to receive the best quality care.

A third presupposition of medical practice is that medical practice is, first and foremost, a one-to-one relationship between physician and patient. Few physicians would deny, of course, that patients who have close family and friendship ties come to the health care system, especially if they are seriously

ill or fear they are, as members of these communities. When an important health care decision needs to be made, the patient who would prefer to make it simply alone and isolated from the communities to which he or she belongs is by far the exception. Few physicians would deny, either, that most forms of health care are given by teams of professionals working together, with each contributing his or her own special expertise. This is obvious in the hospital, where not only nurses and their support staff, but also a whole infrastructure of laboratory personnel, radiologists, dieticians, administrators, social workers, chaplains, and others are needed to work together with physicians, consultants, residents, and perhaps students as well, to provide the best quality care. But the same is often true even in the doctor's private office, where quality care still depends upon the expertise of radiologists and laboratory personnel, and often upon that of nursing professionals and consulting physicians.

It would be possible then, and far from a fiction, to think of health care much more as the activity of a community, or of two communities working together, the community of health professionals with their diverse, but interrelated forms of expertise, and the patient in his or her community of love and friendship. The physician's dominant perception of health care as a one-to-one relationship is not a necessary perception. While there may well be good reasons for it, its impact on social structures which in turn condition the provision of health care in our society certainly deserves to be examined.

Once again medicine, as a profession, is not solely responsible either for the dominance of this preconception within the practice of medicine itself or for the social structures which it fosters and supports in the larger community. Our American culture has long placed its dominant emphasis on the actions and interactions of otherwise disengaged individuals. Communities of mutual responsibility, actions of groups of persons acting as one, and choices by groups of persons, are widely considered sentimental fictions, and their inner dynamics too intangible to merit serious account. So a more communitarian conception of medical practice will have an uphill fight if the dominant one-to-one conception is judged to be in need of change of adjustment.

Again only a sampling of social structures supported by this preconception of medical practice can be described here and only a preliminary evaluation can be offered. First of all, this preconception reinforces the social structures already examined, with their significant inhibiting effects on the provision of the best and most efficient health care. By emphasizing the specific relationship between patient and physician, and relegating their relationships with other health professionals to a secondary status, this structure further reinforces the dominance of the physician's dominant orientation (physiological-biochemical) and approach (crisis-intervention). In a more communitarian understanding of the health care relationship, other orientations and approaches would have something more like 'equal time.'

Secondly, the conception of the health care relationship as primarily one-to-one stunts the ability of many patients to make carefully considered health care decisions. Most adults who are members of close families or have close friends make important decisions in their company and with their assistance and support. But the presumption in favor of a one-to-one relationship means physicians are less likely to communicate with the patient and family as a group. Patients are not all alike, of course, and there are practical challenges in bringing a patient's close family or support community together when an important decision needs to be made. There are also bureaucratic and administrative structures within the health care system which reinforce the separation of the patient from his or her support communities. But the negative effect of isolating patients, especially in times of difficult decision-making, is still a significant responsibility of medicine as well. So medicine's preconception of health care as dominated by the one-to-one relationship of physician and patient deserves thoughtful revision.

Thirdly, the dominance of the one-to-one conception of the health care relationship helped to create and continues to support the myth that the dominant economic structure in medicine is the free market relationship, a bargaining relationship between producer and consumer which results in a voluntary contract. That this conception of medicine is a myth should be evident for at least three reasons. First, the consumer in a true market relationship must be the judge of his or her own need for the product. Otherwise it is impossible for the consumer to make the comparative judgments of price and quality on which the efficiency of the market depends. But in medicine it is the physician who identifies what the patient needs. Second, the free market consumer must be able to judge the comparative merits of alternative products in order to identify the best combination of quality and price. But in medicine it is the physicians who identify the best product, not the patient, and patients are rarely in a position to judge the comparative quality of different physicians' expertise. Thirdly, the free market consumer must retain the option not to buy at all, if an acceptable combination of price and quality cannot be found. When a consumer has lost the option not to buy, then the producers can control the market, destroying its efficiency, while the other chief virtue of the free market, the liberty of the bargainers, is at serious risk as well. But in medicine, at least as we practice it in our society, patients do not generally enter the system until they are already in genuine need of help, or at least see themselves as such. That is, when they enter the system, few of them retain their option not to buy. As such they cannot function as market consumers.[7]

If we continue to think of health care as dominated by free market relationship, when this cannot possibly be true, we will not be able to understand how the economics of health care actually works, we are likely to find the system largely out of our control, and we are likely to see profound inequities in the

distribution of health care resources as a result. That such inequities actually exist is a matter of debate, but strong evidence can surely be given in support of this claim. In any case, it is certainly true that we do not well understand the economics of health care and the system seems to many to be out of control. Moreover, those who would rectify the economic troubles of the health care system simply by restoring a fee-for-service structure are forgetting the reasons just explained why the health care system cannot work like a free market.

Of course the preconception of medical care as a one-to-one relationship cannot be blamed for all the complexities of the economics of health care. But the dominance of the conception of health care as one-to-one can certainly blind physicians to these complexities and can direct the vision of everyone involved away from more communitarian models of the provision of health care. If the impact of economic structures on health care were slight, then the contribution of medical preconceptions to economic structures might be too insignificant to merit the attention of the medical profession. But such is not the case. So as the profession examines this preconception of medical practice, its contribution to economic confusion and possibly to actual maldistribution of health care resources ought to be considered. If it is found wanting, then again the medical profession is obligated to dialogue with and work in concert with the larger community to amend or change it.

STRATEGY AND INDIVIDUAL RESPONSIBILITY

My aim up to this point, using several preconceptions of medical practice and several social structures important to health care as examples, has been threefold. First I have tried to argue that the ethical responsibilities of the medical profession include social ethical responsibilities as well as obligations to individual patients, to the profession, and to fellow physicians. I argued for this conclusion in general terms in the first section, and then more concretely in the second section by showing that specific features of medical practice affect and support social structures which impact negatively on health care. Secondly, I have tried to stimulate reflection about three specific preconceptions of medical practice, about the specific social structures to which these preconceptions contribute, and about the impact, especially the potential for negative impact, of these social structures on health care. Third, I have tried to demonstrate that the social ethics of medicine cannot be separated from the philosophy of medicine. The study of the preconceptions of medical practice is incomplete unless the impact of these preconceptions on the larger community is given serious consideration; and the study of social issues related to medicine will be truncated if attention is not paid to the relevant preconceptions of medical practice.

In this final section I wish to examine two other matters which flow from the foregoing. I must comment, at least briefly, on possible strategies for the profession to use in trying to change those social structures which negatively affect health care. Finally I will discuss the obligations of individual physicians to participate in these strategies.

How can a profession change or adjust widespread social habits of mind and action, even granting that its own preconceptions of its practice have been partially responsible for the existence of these habits? After all, there are other causative factors behind these social structure besides the influence of the medical profession, and the community which possesses these habits is much larger than and changes much more slowly than a single profession like medicine does.

Widespread and deeply engrained social structures will not change overnight, to be sure. So if the profession will accept as success only a sudden transformation of these social habits of mind and action, then failure is assured. But this is certainly unreasonable. The relevant question concerns gradual, incremental change in the social structures which negatively affect health care. How can the medical profession contribute to change of this sort?

The most important point of contact between the medical profession and the larger community is the encounter between physicians, other health professionals, and their patients. The preconceptions of medical practice are communicated to patients and other health professionals in a thousand different actions, words, and judgments. If physicians modify their preconceptions and make these changes habitual, these too will be communicated to patients and other health professionals in a thousand different ways and will in turn be reinforced by the larger community's gradually changing habits of mind and action. In this process of changing social structures, the fact that medicine's preconceptions currently dominate over other groups' is a positive value. (It is a value which may eventually be sacrificed, but not before a truly interactive understanding of the medical profession and a truly communitarian conception of the health care relationship are widespread.) How can the medical profession facilitate this habit-changing process?

The most important thing that the profession can do is to stimulate dialogue and reflection on the part of its members to see how widespread and significant are the effects of the profession's preconceptions of its practice, and to begin to ask if other ways of conceiving of medical practice might not be preferable. The examples studied in the previous section could be a useful starting point. The challenge here is that one of the reasons for being a profession is to *preserve*, to protect what is important from change. The questioning and evaluation of preconceptions of medical practice will frighten some and feel awkward and incomfortable to most members of the profession. But their commitment to

people's health, I have tried to show, requires them to examine and discuss even the basic preconceptions of their practice. The profession as a whole must work intensively to stimulate and support such reflection and dialogue.

The profession's second most important activity in trying to change social structures concerns medical schools and residency programs. It is here that the preconceptions of future physicians' practice are shaped. If medical school faculty and the attendings who supervise residents incorporate revised preconceptions into their teaching and their practice, the students and residents will develop corresponding habits of mind and action to a large extent. If the faculty and attendings urge reflection and dialogue explicitly on the preconceptions of practice and on their impact on the whole society, the students and residents will begin to value such reflection and dialogue and will engage in it on their own initiative. If curricula and exams, priorities in the assignment of course hours and in the appointment of faculty, and the other adminstrative structures of medical schools and residency programs are also modified to facilitate such dialogue and reflection and to make room for the altered preconceptions of medical practice which it will produce, these structures will support the profession's effort to respond to its social ethical obligations.

Finally, the medical profession lobbies, issues formal statements, and engages in public relations activities. It produces journals guided by editorial policies which express and reinforce the profession's presuppositions and commitments. It sponsors conferences and engages informal dialogue, in many forums, with the lay community and with other health professions. In every one of these areas a positive interest in dialogue about the preconceptions of medical practice and their impact on social structures which affect health care would be possible and beneficial. The more open this dialogue is, the more explicitly interactive and thus the more subject to mutual control will be the process by which these social structures are changed and the profession fills its roles.

But what of the individual physician? Is it enough that the individual physician simply affirm the activities of the profession as a whole which I have just described? This much is certainly necessary, but I would argue that the individual physician has an obligation to do more than this.

When an individual becomes a member of a profession, he or she is admitted to that status not merely by other members of the profession, but by the community at large, to whom he or she makes a commitment to properly use the power, based on expertise, which comes with that status.[8] This commitment includes an obligation to participate in the dialogue by which the preconceptions of that profession's practice are affirmed or modified. Therefore it is not enough for the individual physician to lend only passive support to this dialogue. Each physician must begin by reflecting carefully on the preconceptions of his or her own specific practice of medicine, on their currency within medicine in general, and on the impact of these preconceptions on social structures which affect

health care. Each physician ought to initiate dialogue about these matters with other physicians and to use the professional literature, both as reader and as writer, to extend this dialogue still further.

Each physician also has an obligation to communicate revised preconceptions of medical practice to patients, and to engage them in dialogue on these matters and assist them in reshaping their habits of mind and action in corresponding fashion. This will sometimes take the form of explicit instruction or an explicit discussion of medicine's preconceptions. But it will more often occur in discussions of the patients' condition and its causes, of decisions that must be made and the ways of making them, of the elements of the physician-patient relationship as it concretely exists, and so on. The point is to assist patients and their families, and other involved parties, in reflecting on and stretching their conceptions of medicine and health care and in creating, together with the physician, better relationships and a better understanding of health care.

This same dialogue needs to be extended to other health professionals as well. Here these issues can often be raised more explicitly and the impact on relevant social structures of differing professions' preconceptions of practice can be frankly discussed. The physician must be open to learning from other health professionals by stretching his or her own understanding of health care by their imput, and must work to communicate to them the revised preconceptions of medical practice which are the fruit of these efforts at dialogue.

In the present social setting, the physician must take the lead, both with patients and their families, and with other health professionals. If a more communitarian understanding of health care is eventually judged to be preferable, then this dominance of physicians may change. But for now the physician has a special responsibility to take the initiative.

There are many ways in which existing social structures support the best possible health care. But there are also important ways in which these structures impede the best possible care. Not all of these structures are responsive to the influence of physicians as health professionals, and the social ethics of health care must include the study of those which are not so responsive as well as those which are. But insofar as physicians are responsible, both individually and collectively, for contributing to and supporting social structures which affect health care negatively, they are committed to dialogue and to work in concert with the larger community, as it presents itself both in individuals and collectively, to change or adjust these structures.

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NOTES

[1] Knowledge alone, without the experiential component, is not professional expertise. The mid-second year medical student may be a very knowledgable physiologist or biochemist in certain specialized areas, but he or she is not yet a physician.

[2] Freidson develops many elements of this account in *Profession of Medicine* and *Professional Dominance*. See also Beauchamp (1976) and, for a more critical, not to say caustic account of profession, see Illich (1976), Ehrenreich and Ehrenreich (1970), Ehrenreich (1978), and McKnight (1978).

[3] This interactive view of the relationship between profession and the larger community is developed more fully in Ozar (1984) and, applied to dentistry, in Ozar (1985).

[4] See Pellegrino and Thomasma (1981) and Veatch (1981) for examples of more fully developed philosophies of medicine.

[5] While the term 'medicine' is sometimes used to refer to the health care system generally, I use it throughout this essay in the narrower sense in which it refers specifically to the practice of physicians.

[6] See Freidson, *Professional Dominance*, on the dominance of medicine over the other health professions.

[7] To these factors a fourth, more recent circumstance must be added. For several decades the vast majority of health care expenses have been paid through third-party payers. Consequently physician and patient have not ordinarily compared 'products' on the basis of price. Moreover, with regard to the largest expenditures, hospitalization, patients have simply gone where the physician has privileges and received the services which physicians there have ordered. So again the producer-consumer model does not describe the physician-patient relation.

[8] See Ozar (1984) and Ozar (1985) for a fuller account of this point.

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