

Code, Covenant, Contract, or Philanthropy

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Questions in medical ethics cannot be resolved apart from the professional matrix in which most decisions are made. What is the nature of the relationship between physicians and their patients? How best can we conceptualize professional ethics and understand its binding power? The times press these questions, while tradition offers us several starting points, alternative ways of interpreting professional obligations: the concepts of code and covenant, and the allied notions of philanthropy and contract.

The Hippocratic Oath, as Ludwig Edelstein notes in his unsurpassed study of that document (3), contains two distinct sets of obligations—those that pertain to the doctor's treatment of his patients and those that are owed his teacher and his teacher's progeny. Edelstein characterizes the first set of obligations, those owed patients, as an ethical code and the second set, those toward the professional guild, as a covenant.

This distinction between code and covenant is extremely revealing and useful. Code itself, furthermore, may be divided into the

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unwritten codes of practical behavior, transmitted chiefly in a clinical setting from generation to generation of physicians, and into the written codes, beginning with the Hippocratic Oath and concluding with the various revisions of the AMA codes that have had wide currency in this country. Technical proficiency is the prized ideal in the unwritten and informal codes of behavior passed on from doctor to doctor; the ideal of philanthropy (that is, the notion of gratuitous service to humankind) looms large in the more official engraved tablets of the profession. Then, the notion of covenant stands in contrast not only with the ideals of technical proficiency and philanthropy but also with the legal instrument of a contract to which, at first glance, a covenant seems so similar. With these distinctions, then, let us begin.

THE HIPPOCRATIC OATH

As elaborated in the Hippocratic Oath, the duties of a physician toward his patients include a series of absolute prohibitions: against performing surgery, against assisting patients in attempts at suicide or abortion, breaches in confidentiality, and against acts of injustice or mischief toward the patient and his household, including sexual misconduct. More positively, the physician must act always for the benefit of the sick—the chief illustration of which is to apply dietetic measures according to the physician's best judgment and ability—and, more generally, to keep them from harm and injustice. These various professional obligations to the patient have a religious reference, as the physician declares, "In purity and holiness I will guard my life and art," and petitions, "If I fulfill this oath and do not violate it, may it be granted to me to enjoy life and art . . . ; If I transgress it and swear falsely, may the opposite of all this be my lot."

The second set of obligations, directed to the physician's teacher, his teacher's children and his own, require him to accept full filial responsibilities for his adopted father's personal and financial welfare, and to transmit without fee his art and knowledge to the teacher's progeny, to his own, and to other pupils, but only those others who take the oath according to medical law.

It will be the contention of this essay that the development of the

practice of modern medicine, for understandable reasons, has tended to reinforce the ancient distinction between these two obligations, that is, between code and covenant; and that it has opted for code as the ruling ideal in relations to patients. The choice has not had altogether favorable consequences for the moral health of the profession.

THE CHARACTERISTICS OF A CODE

For the purposes of this essay, it can be said, a code shapes human behavior in a fashion somewhat similar to habits and rules. A habit, as Peter Winch has pointed out (9), is a matter of doing the same thing on the same kind of occasion in the same way. A moral rule is distinct from a habit in that the agent in this instance *understands what is meant* by doing the same thing on the same kind of occasion in the same way. Both habits and rules are categorical, universal, and to this degree ahistorical: they do not receive their authority from particular events by which they are authorized or legitimated. They remain operative categorically on all similar occasions: *Never* assist patients in attempts at suicide or abortion; never break a confidence except under certain specified circumstances.

A code is usually categorical and universal in the aforementioned senses, but not in the sense that it is binding on any and all groups. Hammurabi's code is obligatory only for particular peoples. Moreover, inner circles within certain societies—whether professional or social groups—develop their special codes of behavior. We think of code words or special behaviors among friends, workers in the same company, or professionals within a guild. These codes offer directives not only for the content of action, but also for its form. In its concern with appropriate form, a code moves in the direction of the aesthetic. It is concerned not only with what is done but with how it is done; it touches on matters of style and decorum. Thus medical codes include directives not only on the content of therapeutic action, but also on the fitting style for professional behavior including such matters as suitable dress, discretion in the household, appropriate behavior in the hospital, and prohibitions on self-advertisement.

This tendency to move ethics in the direction of aesthetics is best

illustrated in the work of the modern novelist most associated with the ideal of a code. The ritual killing of a bull in the short stories and novels of Hemingway symbolizes an ethic in which stylish performance is everything.

... the bull charged and Villalta charged and just for a moment they became one. Villalta became one with the bull and then it was over.

—Hemingway, *In Our Time*

For the Hemingway hero, there is no question of permanent commitments to particular persons, causes, or places. Robert Jordan of *For Whom the Bell Tolls* does not even remember the “cause” for which he came to Spain to fight. Once he is absorbed in the ordeal of war, the test of a man is not a cause to which he is committed but his conduct from moment to moment. Life is a matter of eating, drinking, loving, hunting, and dying well. Hemingway writes about lovers, but rarely about marriage or the family. Catherine in *Farewell to Arms* and Robert Jordan in *For Whom the Bell Tolls* inevitably must die. Just for a moment, lovers become one and then it is over.

The bullfighter, the wartime lover, the doctor—all alike—must live by a code that eschews involvement; for each there comes a time when the thing is over; matters are terminated by death. But this does not mean that men cannot live beautifully, stylishly, fittingly. Discipline is all. There is a right and a wrong way to do things. And the wrong way usually results from a deficiency in technique or from an excessive preoccupation with one’s ego. The bad bull fighter either lacks technique or he lets his ego—through fear or vanity—get in the way of his performance. The conditions of beauty are technical proficiency and a style wholly purified of disruptive preoccupation with oneself. Literally, however, when the critical moment is consummated, it is over; it cannot shape the future. Partners must fall away; only the code remains.

For several reasons, the medical profession has been attracted to the ideal of code for its interpretation of its ethics. First, a code requires one to subordinate the ego to the more technical question of how a thing is done and done well. At its best, the discipline of a code has an aesthetic value. It encourages a proficiency that is

quietly eloquent. It conjoins the good with the beautiful. Since the technical demands of medicine have become so great, the standards of the guild are transmitted largely by apprenticeship to those whose preeminent skills define the real meaning of the profession without significant remainder. All the rest is a question of disciplining the ego to the point that nervousness, fatigue, faintheartedness, and temptations to self-display (including gross efforts at self-advertisement) have been smoothed away.

A code is additionally attractive in that it does not, in and of itself, encourage personal involvement with the patient; and it helps free the physician of the destructive consequences of that personal involvement. Compassion, in the strictest sense of the term—"suffering with"—has its disadvantages in the professional relationship. It will not do to pretend that one is the second person of the Trinity, prepared to make with every patient the sympathetic descent into his suffering, pain, particular form of crucifixion, and hell. It is enough to offer whatever help one can through finely honed services. It is important to remain emotionally free so as to be able to withdraw the self when those services are no longer pertinent, when as Hemingway says, "it is over."

Finally, a code provides the modern doctor with a basic style of operation that shapes not only his professional but his free time, not only his vocation but his avocations. The self-same pleasure he derives from proficiency in his professional life, he transposes now to his recreational life—flying, skiing, traveling, or sailing. Since his obligations have placed him daily in the precincts of suffering and death he learns that life is available only from moment to moment. As a hard-pressed professional, he knows that both his life and free time are limited—like the soldier's furlough. It makes sense to live by a code that operates from moment to moment savoring pleasure in stylish action. Thus his code not only frees him from some of the awkwardness and distress that sentient beings are prey to in the midst of agony; but, when he is momentarily free of the battle, it provides him with a style and allows him to live, like most warriors who have tasted death, by the canons of hedonism, which money places specially within his reach.

THE IDEAL OF A COVENANT

A covenant, as opposed to a code, has its roots in specific historical events. Like a code, it may give inclusive shape to subsequent behavior, but it always has reference to specific historical exchange between partners leading to a promissory event. Edelstein is quite right in distinguishing code from covenant in the Hippocratic Oath. Rules governing behavior toward patients have a different ring to them from that fealty which a physician owes to his teacher. Loyalty to one's instructor is founded in a specific historical event—that original transaction in which the student received his knowledge and art. He accepts, in effect, a specific gift from his teacher which deserves his lifelong loyalty, a gift that he perpetuates in his own right and turn as he offers his art without fee to his teacher's children and to his own progeny. Covenant ethics is responsive in character.

In its ancient and most influential form, a covenant usually included the following elements: (a) an original experience of gift between the soon-to-be covenanted partners; (b) a covenant promise based on this original or anticipated exchange of gifts, labors, or services; and (c) the shaping of subsequent life for each partner by the promissory event. The scriptures of ancient Israel are littered with such covenants between men and controlled throughout by that singular covenant which embraces all others. The covenant between God and Israel includes the aforementioned elements: (a) a gift—the deliverance of the people from Egypt; (b) an exchange of promises—at Mt. Sinai; and (c) the shaping of all subsequent life by the promissory event. God “marks the forehead” of the Jews forever, as they respond by accepting an inclusive set of ritual and moral commandments by which they will live. These commands are both specific enough (e.g., the dietary laws) to make the future duties of Israel concrete, yet summary enough (e.g., love the Lord thy God with all thy heart . . .) to require a fidelity that exceeds any specification.

The most striking contemporary restatement of an ethic based on covenant is offered by Hemingway's great competitor and contemporary as a novelist—William Faulkner. While the Hemingway hero lives from moment to moment, Faulkner's characters take their bearings from a covenant event. Like Hemingway, Faulkner also

writes about a ritual slaying, but with a difference. In "Delta Autumn," a young boy, Isaac McCaslin, "comes of age" in the course of a hunt:

And the gun levelled rapidly without haste and crashed and he walked to the buck still intact and still in the shade of that magnificent speed and bled it with Sam Father's knife and Sam dipped his hands in the hot blood and marked his face forever. . . .

—Faulkner, "Delta Autumn"

The Hemingway hero slays his bull and then it is over; but young Isaac McCaslin binds the whole of his future in the instant.

I slew you; my bearing must not shame your quitting of life.
My conduct forever onward must become your death.

From then on, just as the marked Jew, the errant, harassed, and estranged Jew, recovers the covenant of Mt. Sinai through ritual renewal, Isaac returns to the delta every autumn to renew the hunt and to suffer his own renewal despite the alienation and pain and defeat which he has subsequently known across a lifetime. This covenant moreover looms over all else—his relationship to the land, to women, to blacks, to all of which and whom he is bound.

For some of the reasons already mentioned, the bond of covenant, in the classical period, tended to define and bind together medical colleagues to one another, but it did not figure large in interpreting the relations between the doctor and his patients. The doctor receives his professional life from his teacher; this gift establishes a bond between them and prompts him to assume certain lifetime duties not only toward the teacher (and his financial welfare), but toward his children. This symbolic bond with one's teacher acknowledged in the Hippocratic Oath is strengthened in modern professional life by all those exchanges between colleagues—referrals, favors, personal confidences, and collaborative work on cases. Thus loyalty to colleagues is a responsive act for gifts already, and to be, received.

Duties to patients are not similarly interpreted in the medical codes as a responsive act for gifts or services received. This is the

essential feature of covenant which is conspicuously missing in the interpretation of professional duties from the Hippocratic Oath to the modern codes of the AMA.

**THE CODE IDEAL OF PHILANTHROPY
vs. COVENANTAL INDEBTEDNESS**

The medical profession includes in its written codes an ideal that Hemingway never shared and that seldom looms large in the ethic of any self-selected inner group—the ideal of philanthropy. The medical profession proclaims its dedication to the service of mankind. This ideal is implicitly at work in the Hippocratic Oath and the culture out of which it emerged (5); it continues in the Code of Medical Ethics originally adopted by the American Medical Association at its national convention in 1847, and it is elaborated in contemporary statements of that code.

This ideal of service, in my judgment, succumbs to what might be called the conceit of philanthropy when it is assumed that the professional's commitment to his fellowman is a gratuitous, rather than a responsive or reciprocal, act. Statements of medical ethics that obscure the doctor's prior indebtedness to the community are tainted with the odor of condescension. The point is obvious if one contrasts the way in which the code of 1847 interprets the obligations of patients and the public to the physician, as opposed to the obligations of the physician to the patient and the public. On this particular question, I see no fundamental change from 1847 to 1957.

Clearly the duties of the patient are founded on what he has received from the doctor:

The members of the medical profession, upon whom is enjoined the performance of so many important and arduous duties toward the community, and who are required to make so many sacrifices of comfort, ease, and health, for the welfare of those who avail themselves of their services, certainly have a right to expect a just sense of the duties which they owe to their medical attendants. (1)

In like manner, the section on the Obligations of the Public to Physicians emphasizes those many gifts and services which the

public has received from the medical profession and which are the basis for its indebtedness to the profession.

The benefits accruing to the public, directly and indirectly, from the active and unwearied beneficence of the profession, are so numerous and important, that physicians are justly entitled to the utmost consideration and respect from the community. (2)

But turning to the preamble for the physician's duties to the patient and the public, we find no corresponding section in the code of 1847 (or 1957) which founds the doctor's obligations on those gifts and services which he has received from the community. Thus we are presented with the picture of a relatively self-sufficient monad, who, out of the nobility and generosity of his disposition and the gratuitously accepted conscience of his profession, has taken upon himself the noble life of service. The false posture in all this cries out in one of the opening sections of the 1847 code. Physicians "should study, also, in their deportment so as to unite tenderness with firmness, and condescension with authority, so as to inspire the minds of their patients with gratitude, respect and confidence."

I do not intend to demean the specific content of those duties which the codes set forth in their statement of the duties of physicians to their patients, but I am critical of the setting or context in which they are placed. Significantly the code refers to the *Duties* of physicians to their patients but to the *Obligations* of patients to their physicians. The shift from "Duties" to "Obligations" may seem slight, but, in fact, I believe it is a revealing adjustment in language. The AMA thought of the patient and public as *indebted* to the profession for its services but the profession has accepted its *duties* to the patients and public out of noble conscience rather than a reciprocal sense of indebtedness.

Put another way, the medical profession imitates God not so much because it exercises power of life and death over others, but because it does not really think itself beholden, even partially, to anyone for those duties to patients which it lays upon itself. Like God, the profession draws its life from itself alone. Its action is wholly gratuitous.

Now, in fact, the physician is in very considerable debt to the community. The first of these debts is already adumbrated in the

original Hippocratic Oath. He is obliged to someone or some group for his education. In ancient times, this led to a special sense of covenant obligation to one's teacher. Under the conditions of modern medical education, this indebtedness is both substantial (far exceeding the social investment in the training of any other professional) and widely distributed (including not only one's teachers but those public monies on the basis of which the medical school, the teaching hospital, and research into disease are funded).

In view of the fact that many more qualified candidates apply for medical school than can be admitted and many more doctors are needed than the schools can train, the doctor-to-be has a second order of indebtedness for privileges that have almost arbitrarily fallen his way. While the 1847 code refers to the "privileges" of being a doctor it does not specify the social origins of those privileges. Third, and not surprisingly, the codes do not make reference to that extraordinary social largesse that befalls the physician, in payment for services, in a society where need abounds and available personnel is limited. Further, the codes do not concede the indebtedness of the physician to those patients who have offered themselves as subjects for experimentation or as teaching material (either in teaching hospitals or in the early years of practice). Early practice includes, after all, the element of increased risk for patients who lay their bodies on the line as the doctor "practices" on them. The pun in the word but reflects the inevitable social price of training. This indebtedness to the patient was most recently and eloquently acknowledged by Judah Folkman, M.D., of Harvard Medical School in a Class Day Address.

In the long run, it is better if we come to terms with the uncertainty of medical practice. Once we recognize that all our efforts to relieve suffering might on occasion cause suffering, we are in a position to learn from our mistakes and appreciate the debt we owe our patients for our education. It is a debt which we must repay—it is like tithing.

I doubt that the debt we accumulate can be repaid our patients by trying to reduce the practice of medicine to a forty-hour week, or by dissolving the quality of our residency programs just because certain groups of residents in the country

have refused, through legal tactics, to be on duty more than every fourth or fifth night or any nights at all.

And it can't be repaid by refusing to see Medicaid patients when the state can't afford to pay for them temporarily.

But we can repay the debt in many ways. We can attend postgraduate courses and seminars, be available to patients at all hours, teach, take recertification examinations; maybe in the future even volunteer for national service; or, most difficult of all, carry out investigation or research. (4)

The physician, finally, is indebted to his patients not only for a start in his career. He remains unceasingly in their debt in its full course. This continuing reciprocity of need is somewhat obscured for we think of the mature professional as powerful and authoritative rather than needy. He seems to be a self-sufficient virtuoso whose life is derived from his competence while others appear before him in their neediness, exposing their illness, their crimes, or their ignorance, for which the professional—doctor, lawyer, or teacher—offers remedy.

In fact, however, a reciprocity of giving and receiving is at work in the professional relationship that needs to be acknowledged. In the profession of teaching, for example, the student needs the teacher to assist him in learning, but so also the professor needs his students. They provide him with regular occasion and forum in which to work out what he has to say and to rediscover his subject afresh through the discipline of sharing it with others. Likewise, the doctor needs his patients. No one can watch a physician nervously approach retirement without realizing how much he has needed his patients to be himself.

A covenantal ethics helps acknowledge this full context of need and indebtedness in which professional duties are undertaken and discharged. It also relieves the professional of the temptation and pressure to pretend that he is a demigod exempt from human exigency.

CONTRACT OR COVENANT

While criticizing the ideal of philanthropy, I have emphasized the elements of exchange, agreement, and reciprocity that mark the

professional relationship. This leaves us with the question as to whether the element of the gratuitous should be suppressed altogether in professional ethics. Does the physician merely respond to the social investment in his training, the fees paid for his services, and the terms of an agreement drawn up between himself and his patients, or does some element of the gratuitous remain?

To put this question another way: is covenant simply another name for a contract in which two parties calculate their own best interests and agree upon some joint project in which both derive roughly equivalent benefits for goods contributed by each? If so, this essay would appear to move in the direction of those who interpret the doctor-patient relationship as a legal agreement and who want, on the whole, to see medical ethics draw closer to medical law.

The notion of the physician as contractor has certain obvious attractions. First, it represents a deliberate break with more authoritarian models (such as priest or parent) for interpreting the role. At the heart of a contract is informed consent rather than blind trust; a contractual understanding of the therapeutic relationship encourages full respect for the dignity of the patient, who has not, through illness, forfeited his sovereignty as a human being. The notion of a contract includes an exchange of information on the basis of which an agreement is reached and a subsequent exchange of goods (money for services); it also allows for a specification of rights, duties, conditions, and qualifications limiting the agreement. The net effect is to establish some symmetry and mutuality in the relationship between the doctor and patient.

Second, a contract provides for the legal enforcement of its terms—on both parties—and thus offers both parties some protection and recourse under the law for making the other accountable for the agreement.

Finally, a contract does not rely on the pose of philanthropy, the condescension of charity. It presupposes that people are primarily governed by self-interest. When two people enter into a contract, they do so because each sees it to his own advantage. This is true not only of private contracts but also of that primordial social contract in and through which the state came into being. So argued the theorists of the 18th century. The state was not established by some

heroic act of sacrifice on the part of the gods or men. Rather men entered into the social contract because each found it to his individual advantage. It is better to surrender some liberty and property to the state than to suffer the evils that would beset men except for its protection. Subsequent enthusiasts about the social instrument of contracts (7) have tended to measure human progress by the degree to which a society is based on contracts rather than status. In the ancient world, the Romans made the most striking advances in extending the areas in which contract rather than custom determined commerce between people. In the modern world, the bourgeoisie extended the instrumentality of contracts farthest into the sphere of economics; the free churches, into the arena of religion. Some educationists today have extended the device into the classroom (as students are encouraged to contract units of work for levels of grade); more recently some women's liberationists would extend it into marriage; and still others would prefer to see it define the professional relationship. The movement, on the whole, has the intention of laicizing authority, legalizing relationships, activating self-interest, and encouraging collaboration.

In my judgment, some of these aims of the contractualists are desirable, but it would be unfortunate if professional ethics were reduced to a commercial contract without significant remainder. First, the notion of contract suppresses the element of gift in human relationships. Earlier I verged on denying the importance of this ingredient in professional relations, when I criticized the medical profession for its conceit of philanthropy, for its self-interpretation as the great giver. In fact, this earlier objection should be limited to the failure of the medical profession to acknowledge those gifts and goods it has itself received. It is unbecoming to adopt the pose of spontaneous generosity when the profession has received so much from the community and from patients, past and present.

But the contractualist approach to professional behavior falls into the opposite error of minimalism. It reduces everything to tit-for-tat: do no more for your patients than what the contract calls for; perform specified services for certain fees and no more. The commercial contract is fitting instrument in the purchase of an appliance, a house, or certain services that can be specified fully in advance of delivery. The existence of a legally enforceable agreement in pro-

fessional transactions may also be useful to protect the patient or client against the physician or lawyer whose services fall below a minimal standard. But it would be wrong to reduce professional obligation to the specifics of a contract alone.

Professional services in the so-called helping professions are directed to subjects who are in the nature of the case rather unpredictable. One deals with the sickness, ills, crimes, needs, and tragedies of humankind. These needs cannot be exhaustively specified in advance for each patient or client. The professions must be ready to cope with the contingent, the unexpected. Calls upon services may be required that exceed those anticipated in a contract or for which compensation may be available in a given case. These services, moreover, are more likely to be effective in achieving the desired therapeutic result if they are delivered in the context of a fiduciary relationship that the patient or client can really trust.

THE LIMITATIONS OF CONTRACT

Contract and covenant, materially considered, seem like first cousins; they both include an exchange and an agreement between parties. But, in spirit, contract and covenant are quite different. Contracts are external; covenants are internal to the parties involved. Contracts are signed to be expediently discharged. Covenants have a gratuitous, growing edge to them that nourishes rather than limits relationships. To the best of my knowledge, no one has put quite so effectively the difference between the two as the novelist already cited in the earlier discussion of covenant.

At the outset of Faulkner's *Intruder in the Dust*, a white boy, hunting with young blacks, falls into a creek on a cold winter's day. After the boy clambers out of the river, Lucas Beauchamp, a proud, commanding black man, brings him, shivering, to his house where Mrs. Beauchamp takes care of him. She takes off his wet clothes and wraps him in Negro blankets, feeds him Negro food, and warms him by the fire.

When his clothes dry off, the boy dresses to go, but, uneasy about his debt to the other, he reaches into his pocket for some coins and offers seventy cents compensation for Beauchamp's help. Lucas rejects the money firmly and commands the two black boys to pick

up the coins from the floor where they have fallen and return them to the white boy.

Shortly thereafter, still uneasy about the episode at the river and his frustrated effort to pay off Lucas for his help, the boy buys some imitation silk for Lucas's wife and gets his Negro friend to deliver it. But a few days later, the white boy goes to his own backdoor stoop only to find a jug of molasses left there for him by Lucas. So he is back where he started, beholden to the black man again.

Several months later, the boy passes Lucas on the street and scans his face closely, wondering if the black man remembers the incident between them. He can't be sure. Four years pass, and Lucas is accused of murdering a white man. He is scheduled to be taken to the jail. The boy goes early before the crowd gathers and ponders whether the old man remembers their past encounter. Just as Lucas is about to enter the jailhouse, he wheels and points his long arm in the direct of the boy and says, "Boy, I want to see you." The boy obeys and visits Lucas in the jailhouse, and eventually he and his aunt are instrumental in proving Lucas's innocence.

Faulkner's story is a parable for the relationship of the white man to the black in the South. The black man has labored in the white man's fields, built and cared for his houses, fed, clothed, and nurtured his children. In accepting these labors, the white man has received his life and substance from the black man over and over again. But he resists this involvement and tries to pay off the black with a few coins. He pretends that their relationship is transient and external, to be managed at arm's length.

For better or for worse, blacks and whites in this country are bound up in a common life and destiny together. The problem between them will not be resolved until they accept the covenant between them which is entailed in the original acceptance of labor.

There is a donative element in the nourishing of covenant—whether it is the covenant of marriage, friendship, or professional relationship. Tit-for-tat characterizes a commercial transaction, but it does not exhaustively define the vitality of that relationship in which one must serve and draw upon the deeper reserves of another.

This donative element is important not only in the doctor's care of the patient but in other aspects of health care. In a fascinating study of *The Gift Relationship*, the late Richard M. Titmuss

compares the British system of obtaining blood by donations with the American partial reliance on the commercial purchase and sale of blood (8). The British system obtains more and better blood, without the exploitation of the indigent, which the American system has condoned and which our courts have encouraged when they refused to exempt nonprofit blood banks from the antitrust laws. By court definition, blood exchange becomes a commercial transaction in the United States. Titmuss expanded his theme from human blood to social policy by offering a sober criticism of the increased commercialism of American medicine and society at large. Recent court decisions have tended to shift more and more of what had previously been considered as services into the category of commodity transactions, with negative consequences he believes for the health of health delivery systems.^a Hans Jonas has had to reckon with the importance of voluntary sacrifice to the social order in a somewhat comparable essay on "Human Experimentation." Others have done so on the subject of organ transplants.

The kind of minimalism encouraged by a contractualist understanding of the professional relationship produces a professional too grudging, too calculating, too lacking in spontaneity, too quickly exhausted to go the second mile with his patients along the road of their distress.

Contract medicine not only encourages minimalism, it also provokes a peculiar kind of maximalism, the name for which is "defensive medicine." Especially under the pressure of malpractice suits, doctors are tempted to order too many examinations and procedures for self-protection. Paradoxically, contractualism simultaneously tempts the doctor to do too little and too much for the patient: too little in that one extends oneself only to the limits of what is specified in the contract; yet, at the same time, too much in that one orders procedures useful in protecting oneself as the contractor even though they are not fully indicated by the condition of the patient. The link between these apparently contradictory strategies of too little and too much is the emphasis in contractual decisions grounded in self-interest.

a. Titmuss does not observe that physicians in the United States had already prepared for this commercialization of medicine by their substantial fees for services (as opposed to salaried professors in the teaching field or salaried health professionals in other countries).

Three concluding objections to contractualism can be stated summarily. Parties to a contract are better able to protect their self-interest insofar as they are informed about the goods bought and sold. Insofar as contract medicine encourages increased knowledge on the part of the patient, well and good. Nevertheless the physician's knowledge so exceeds that of his patient that the patient's knowledgeability alone is not a satisfactory constraint on the physician's behavior. One must, at least in part, depend upon some internal fiduciary checks which the professional and his guide take on.

Another self-regulating mechanism in the traditional contractual relationship is the consumer's freedom to shop and choose among various vendors of services. Certainly this freedom of choice needs to be expanded for the patient by an increase in the number of physicians and paramedical personnel. However, the crisis circumstances under which medical services are often needed and delivered does not always provide the consumer with the kind of leisure or calm required for discretionary judgment. Thus normal marketplace controls cannot be fully relied upon to protect the consumer in dealings with the physician.

For a final reason, medical ethics should not be reduced to the contractual relationship alone. Normally conceived, ethics establishes certain rights and duties that transcend the particulars of a given agreement. The justice of any specific contract may then be measured by these standards. If, however, such rights and duties adhere only to the contract, then a patient might legitimately be persuaded to waive his rights. The contract would solely determine what is required and permissible. An ethical principle should not be waivable (except to give way to a higher ethical principle). Professional ethics should not be so defined as to permit a physician to persuade a patient to waive rights that transcend the particulars of their agreement.

TRANSCENDENCE AND COVENANT

This essay has developed two characteristics of covenantal ethics in the course of contrasting it with the ideal of philanthropy and the

legal instrument of contracts. As opposed to the ideal of philanthropy that pretends to wholly gratuitous altruism, covenantal ethics places the service of the professional within the full context of goods, gifts, and services received; thus covenantal ethics is responsive. As opposed to the instrument of contract that presupposes agreement reached on the basis of self-interest, covenantal ethics may require one to be available to the covenant partner above and beyond the measure of self-interest; thus covenantal ethics has an element of the gratuitous in it.

We have to reckon now with the potential conflict between these characteristics. Have we developed our notion of covenant too reactively to alternatives without paying attention to the inner consistency of the concept itself? On the one hand, we had cause for suspicion of those idealists who founded professional duties on a philanthropic impulse, without so much as acknowledging the sacrifice of others by which their own lives have been nourished. Then we had reasons for drawing back from those legal realists and positivists who would circumscribe professional life entirely within the calculus of commodities bought and sold. But now, brought face to face, these characteristics conflict. Response to debt and gratuitous service seem opposed principles of action.

Perhaps our difficulty results from the fact that we have abstracted the concept of covenant from its original context within the transcendent. The indebtedness of a human being that makes his life—however sacrificial—inescapably responsive cannot be fully appreciated by totaling up the varying sacrifices and investments made by others in his favor. Such sacrifices are there; and it is lacking in honesty not to acknowledge them. But the sense that one is inexhaustibly the object of gift presupposes a more transcendent source of donative activity than the sum of gifts received from others. For the Biblical tradition this transcendent was the secret root of every gift between human beings, of which the human order of giving and receiving could only be a sign. Thus the Jewish scriptures enjoin: when you harvest your crops, do not pick your fields too clean. Leave something for the sojourner for you were once sojourners in Egypt. Farmers obedient to this injunction were responsive, but not simply mathematically responsive to gifts received from the Egyptians or from strangers now drifting through

their own land. At the same time, their actions could not be construed as wholly gratuitous. Their ethic of service to the needy flowed from Israel's original and continuing state of neediness and indebtedness before God. Thus action which at a human level appears gratuitous, in that it is not provoked by a specific gratuity from another human being, is at its deepest level but gift answering to gift. This responsiveness is theologically expressed in the New Testament as follows: "In this is love, not that we loved God, but that he loved us. . . . if God so loved us, we also ought to love one another" (1 *John* 4:10-11). In some such way, covenant ethics shies back from the idealist assumption that professional action is and ought to be wholly gratuitous, and from the contractualist assumption that it be carefully governed by quotidian self-interest in every exchange.

A transcendent reference may also be important not only in setting forth the proper context in which human service takes place but also in laying out the specific standards by which it is measured. Earlier we noted some dangers in reducing rights and duties to the terms of a particular contract. We observed the need for a transcendent norm by which contracts are measured (and limited). By the same token, rights and duties cannot be wholly derived from the particulars of a given covenant. What limits ought to be placed on the demands of an excessively dependent patient? At what point does the keeping of one covenant do an injustice to obligations entailed in others? These are questions that warn against a covenantal ethics that sentimentalizes any and all involvements, without reference to a transcendent by which they are both justified and measured.

FURTHER REFLECTIONS ON COVENANT

So far we have discussed those features of a covenant that affect the doctor's conduct toward his patient. The concept of covenant has further consequences for the patient's self-interpretation, for the accountability of health institutions, for the placement of institutional priorities within other national commitments, and, finally, for such collateral problems as truth-telling.

Every model for the doctor/patient relationship establishes not

only a certain image of the doctor, but also a specific concept of the self. The image of the doctor as priest or parent encourages dependency in the patient. The image of the doctor as skillful technician prompts the patient to think less in terms of his personal dependence, but still it encourages a somewhat impersonal passivity, with the doctor and his technical procedures the only serious agent in the relationship. The image of the doctor as covenanter or contractor bids the patient to become a more active participant both in the prevention and the healing of the disease. He must bring to the partnership a will to life and a will to health.

Differing views of disease are involved in these differing patterns of relationship to the doctor. Disease today is usually interpreted by the layman as an extraordinary state, discrete and episodic, disjunct from the ordinary condition of health. Illness is a special time when the doctor is in charge and the layman renounces authority over his life. This view, while psychologically understandable, ignores the growth during apparent periods of health of those pathological conditions that invite the dramatic breakdown when the doctor "takes over."

The cardiovascular accident is a case in point. Horacio Fabrega (6) has urged an interpretation of disease and health that respects more fully the processive rather than episodic character of both disease and health. This interpretation, I assume, would encourage the doctor to monitor more continuously health/disease than ordinarily occurs today, to share with the patient more fully the information so obtained, and to engage the layperson in a more active collaboration with the doctor in health maintenance.

The concept of covenant has two further advantages for defining the professional relationship, not enjoyed by models such as parent, friend, or technician. First, covenant is not so restrictively personal a term as parent or friend. It reminds the professional community that it is not good enough for the individual doctor to be a good friend or parent to the patient; that it is important also for whole institutions—the hospital, the clinic, the professional group—to keep covenant with those who seek their assistance and sanctuary. Thus the concept permits a certain broadening of accountability beyond personal agency.

At the same time, however, the notion of covenant also permits

one to set professional responsibility for this one human good (health) within social limits. The professional covenant concerning health should be situated within a larger set of covenant obligations that both the doctor and patient have toward other institutions and priorities within the society at large. The traditional models for the doctor/patient relationship (parent, friend) tend to establish an exclusivity of relationship that obscures those larger responsibilities. At a time when health needs command 120 billion dollars out of the national budget, one must think about the place held by the obligation to the limited human good of health among a whole range of social and personal goods for which men are compacted together as a society.

A covenantal ethic has implications for other collateral problems in biomedical ethics, some of which have been explored in the searching work of Paul Ramsey, *The Patient As Person*. I will restrict myself simply to one issue that has not been viewed from the perspective of covenant: the question of truth-telling.

Key ingredients in the notion of covenant are promise and fidelity to promise. The philosopher J. I. Austin drew the distinction, now famous, between two kinds of speech: descriptive and performative utterances. In ordinary declarative or descriptive sentences, one describes a given item within the world. (It is raining. The tumor is malignant. The crisis is past.) In performative utterances, one does not merely describe a world; in effect, one alters the world by introducing an ingredient that would not be there apart from the utterance. Promises are such performative utterance. (I, John, take thee, Mary. We will defend your country in case of attack. I will not abandon you.) To make or to go back on a promise is a very solemn matter precisely because a promise is world-altering.

In the field of medical ethics, the question of truth-telling has tended to be discussed entirely as a question of descriptive speech. Should the doctor, as technician, tell the patient he has a malignancy or not? If not, may he lie or must he merely withhold the truth?

The distinction between descriptive and performative speech expands the question of the truth in professional life. The doctor, after all, not only tells descriptive truths, he also makes or implies promises. (I will see you next Tuesday; or, Despite the fact that I cannot cure you, I will not abandon you.) In brief, the moral question for

the doctor is not simply a question of telling truths, but of being true to his promises. Conversely, the total situation for the patient includes not only the disease he's got, but also whether others ditch him or stand by him in his extremity. The fidelity of others will not eliminate the disease, but it affects mightily the human context in which the disease runs its course. What the doctor has to offer his patient is not simply proficiency but fidelity.

Perhaps more patients could accept the descriptive truth if they experienced the performative truth. Perhaps also they would be more inclined to believe in the doctor's performative utterances if they were not handed false diagnoses or false promises. That is why a cautiously wise medieval physician once advised his colleagues: "Promise only fidelity!"

THE PROBLEM OF DISCIPLINE

The conclusion of this essay is not that covenantal ethics should be preferred to the exclusion of some of those values best symbolized by code and contract. If we turn now to the problem of professional discipline, we can see that both alternatives have resources for self-criticism.

Those who live by a code of technical proficiency have a standard on the basis of which to discipline their peers. The Hemingway novel, especially *The Sun Also Rises*, is quite clear about this. Those who live by a code know how to ostracize deficient peers. Indeed, any "in-group," professional or otherwise, can be quite ruthless about sorting out those who are "quality" and those who do not have the "goods." Medicine is no exception. Ostracism, in the form of discreetly refusing to refer patients to a doctor whose competence is suspected, is probably the commonest and most effective form of discipline in the profession today.

Defenders of an ethic based on code might argue further that deficiencies in enforcement today result largely from too strongly developed a sense of covenantal obligations to colleagues and too weakly developed a sense of code. From this perspective, then, covenant is the source of the problem in the profession rather than the basis for its amendment. Covenantal obligation to colleagues inhibits the enforcement of code.

A code alone, however, will not in and of itself solve the problem of professional discipline. It provides a basis for excluding from one's own inner circle an incompetent physician. But, as Eliot Freidson has pointed out in *Professional Dominance*, under the present system the incompetent professional, when he is excluded from a given hospital, group practice, or informal circle of referrals, simply moves his practice and finds another circle of people of equal incompetence in which he can function. It will take a much stronger, more active and internal sense of covenant obligation to patients on the part of the profession to enforce standards within the guild beyond local informal patterns of ostracism. In a mobile society with a scarcity of doctors, local ostracism simply hands on problem-physicians to other patients elsewhere. It does not address them.

Code patterns of discipline not only fall short of adequate protection for the patient; they may also fail in collegial responsibility to the troubled physician. To ostracize may be the lazy way of handling a colleague when it fails altogether to make a first attempt at remedy and to address the physician himself in his difficulty.

At the same time, it would be unfortunate if the indispensable interest and pride of the medical profession in technical proficiency were allowed to lapse out of an expressed preference for a professional ethic based on covenant. Covenant fidelity to the patient remains unrealized if it does not include proficiency. A rather sentimental existentialism unfortunately assumes that it is enough for human beings to be "present" to one another. But in crisis, the ill person needs not simply presence but skill, not just personal concern but highly disciplined services targeted on specific needs. Code behavior, handed down from doctor to doctor, is largely concerned with the transmission of technical skills. Covenant ethics, then, must include rather than exclude the interests of the codes.

Neither does this essay conclude with a preference for covenant to the total exclusion of the interests of enforceable contract. While the reduction of medical ethics to contract alone incurs the danger of minimalism, patients ought to have recourse against those physicians who fail to meet minimal standards. One ought not to be dependent entirely upon disciplinary measures undertaken within

the profession. There ought to be appeal to the law in cases of malpractice and for breach of contract explicit or implied.

On the other hand, in the case of an injustice a legal appeal cannot be sustained without assistance and testimony from physicians who take their obligations to patients seriously. If, in such cases, fellow physicians simply herd around and protect their colleague like a wounded elephant, the patient with just cause is not likely to get far. Thus the instrument of contract and other avenues of legal redress can be sustained only by a professional sense of obligation to the patient. Needless to say, it would be better for all concerned if professional discipline and continuing education were so vigorously pursued within the profession as to cut down drastically on the number of cases that needed to reach the courts.

The author inclines to accept covenant as the most inclusive and satisfying model for framing questions of professional obligation. Covenant fidelity includes the code obligation to become technically proficient; it reenforces the legal duty to meet the minimal terms of contract; but it also requires much more. This surplus of obligation moreover may redound not only to the benefit of patients but also to the advantage of troubled colleagues and their welfare.

REFERENCES

1. American Medical Association. Code of medical ethics, May 1847. Chap. 1, Art. 2, Obligations of patients to their physicians. Chicago: American Medical Association Press; 1897.
2. American Medical Association. Code of medical ethics, May 1847. Chap. 3, Art. 2, Obligations of the public to physicians. Chicago: American Medical Association Press; 1897.
3. Edelstein L. Ancient medicine. Baltimore: Johns Hopkins; 1967.
4. Editorial and comment. New York Times, 1975 Jun 6.
5. Entralgo PL. Doctor and patient. New York: McGraw-Hill; 1969. An analysis of the classic fusion of *techne* with *philanthropia*; skill in the art of healing combined with a love of mankind defines the good physician.
6. Fabrega H Jr. Concepts of disease: logical features and social implications. *Perspect Biol Med*. 1972; 15:583-616.
7. Maine HS. Ancient law. London: Oxford University Press; 1931.
8. Titmuss RM. The gift relationship: from human blood to social policy. New York: Pantheon; 1971.
9. Winch P. The idea of a social science and its relation to philosophy. New York: Humanities Press; 1958.