The Nature of Supererogation and its Application in Medical Practice

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Abstract

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This thesis emphasises the need for doctors' professional duties to be bound firmly together with their moral obligations; there is danger for the patient when there is a divergence. I believe that the consideration and practice of supererogation acts as a means to further this union. I argue for its inclusion in medical practice.

Acts of supererogation go beyond the requirements of duty. The concept has roots in Christianity, and was most fully developed by St Thomas Aquinas, the practice being seen as a route to perfection. It came under attack during the Reformation; for Protestants, salvation was not to be earned by good works, it was only bestowed by the grace of God.

The concept has largely disappeared from everyday usage in a secular society, nevertheless there is an expectation that members of the caring professions should embrace supererogation to some extent. Doctors have lost an understanding of the subject, hampered by the professionalization of medicine.

This thesis illustrates the concept in its practical application and provides a framework of three different models of supererogation. I look to the work of Kenneth E. Kirk and Stanley Hauerwas in theology, and I look at the philosophy of Emmanuel Levinas and Iris Murdoch to support my claims. Examples from literary sources, rather than medical case histories which are often too businesslike in tone, illustrate the complexity of what takes place between patient and doctor.

Doctors might fail to see what is important; they need the faculty of moral perception and also imagination to think of what more can be done for patients as well as wisdom to judge if this can be done safely. I believe that my third model of supererogation could be put into practice for the benefit of both patients and doctors.

The Nature of Supererogation and its Application in Medical Practice

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Submitted for the Qualification of PhD

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2022

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Declaration

This research is the product of my own work, and the work of others has been properly acknowledged throughout.

Statement of Copyright

Acknowledgement

Professor Robert Song, with gratitude for the excellent and generous supervision over six years.

Dedication

To Christina, for many years of support and loving forbearance.

INTRODUCTION

This thesis asks, in this age of biomedicine, should doctors' responsibilities towards their patients include some notion of supererogation, and if so, how should it be understood. I claim that the great benefits of biomedicine have obscured doctors' ordinary, person-to-person obligations to their patients. Accounts of doctors found in the humanities throw light on this fundamental question, and so this thesis includes the resources of philosophy, theology, art and literature.

This account is primarily a work of moral philosophy rather than moral theology. It is based on my long experience as a doctor in the NHS, primarily in general practice, and some personal examples are provided as illustrations. It is argued that the humanities can provide us with a better way of seeing what is of importance to patients, and can thus help us to become better doctors. My own reading has informed my practice, and this includes a broad range of sources. Doctors are encouraged to reflect continually on their practice in the light of supererogation, and if this habit had been adopted early in my career I believe I would have been a better doctor as a result. While we can usually get by without the insights and wisdom obtained from wide reading, and indeed most patients can be treated in a straight-forward manner and might not wish to be spoken to in a deep and probing way, yet in those cases where we cannot get to the bottom of the patient's illness then such insights from the humanities are strongly called for. They throw light on patients' suffering, especially when that is latent, not manifest. That is often at the heart of chronic diseases and of those disordered states of mind which cannot easily be put into words. I do not know of any other study which has emphasised the importance of the humanities to medical practice as seen through the lens of supererogation.

Supererogation is defined as the going beyond the requirements of obligation; in medical terms this can be thought of as simply going beyond the call of duty. The performance of supererogatory acts is desirable but not essential, and it is hard to come to terms with this optional quality. A medical example illustrates this. In the staircase of the North Wing of St Bartholomew's Hospital in London are two large murals painted by William Hogarth in the 1730s. One shows Christ at the Pool of

Bethesda healing the sick, the other shows the Good Samaritan. While healing the sick is straightforwardly the work of medicine, caring for others is problematic: it is open-ended; we have a duty to come to the aid of those who have been attacked on the road, yet the dividing line between first-aid and continuing care is hard to trace.

The Good Samaritan shows that supererogation, though optional, is waiting in the wings for doctors, and there is a presumption that doctors should be willing to embrace it to some degree. At Postman's Park in London, a Victorian memorial garden to those who gave their lives for others, there are commemorative plaques giving brief notices of heroic action. Two doctors separately died of diphtheria after putting duty to patients before their own protection.[1]

Medical practice is characterised by routine and unquestioned pragmatism, and our business-as-usual approach seeks to define neither the limits of duty nor the extent of supererogation. It might be that the optional nature of supererogation makes the notion hard to grasp; this is seen especially when doctors are working under pressure. At present doctors and health care professionals caught up in the COVID 19 pandemic are working without seeking to draw a boundary between duty and supererogation; for example in the first year of the pandemic they continued to work despite the inadequacy of the provision and quality of PPE (personal protective equipment). This lack of definition between duty and supererogation could be seen as an example of 'Loss of Problems', a condition described by Wittgenstein,[2] and doctors would have a better understanding of their duties, and what it means to work beyond duty, by thinking more deeply about supererogation. This thesis invites doctors to explore this issue in a period of calm.

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1 The plaques are inscribed: 'Samuel Rabbeth Medical Officer of the Royal Free Hospital who tried to save a child suffering from diphtheria at the cost of his own life October 26, 1884' and 'William Lucas Freer M.R.C.S. L.L.D. at Middlesex Hospital Risked poison for himself rather than lessen any chance of saving a child's life and died Oct 8th 1893'.

2 'Some philosophers (or whatever you like to call them) suffer from what may be called "loss of problems". Then everything seems quite simple to them, no deep problems seem to exist any more, the world becomes broad and flat and loses all depth, and what they write becomes broad and flat and loses all depth, and what they write becomes immeasurably shallow and trivial. Russell and H.G. Wells suffer from this.' From Ludwig Wittgenstein, *Zettel,* ed. by G.E.M. Anscombe and G.H. von Wright; trans.by G.E.M. Anscombe (Oxford: Blackwell, 1967), 82e, section 456.

Supererogation is complex both in theory and in application, and I am hoping to build up a picture which is both philosophically rich and medically illuminating. It is a useful tool to point us in a new direction, moving away from the insouciance of the biomedical approach to something more thoughtful and reflective. What is put forward is a sense of supererogation pointing doctors in the direction of professional and personal excellence, a force pulling doctors forward, transcending the narrow rectitude of duty and focussing on the *telos* of medicine. This is intimately bound up with both technical excellence and an imaginative sense of what more might be done for patients.

By way of illustration of the need for doctors to reflect on their behaviour I include the following personal example. This demonstrates how novelists can remove some obstacle within us, giving us insight which cannot be obtained without their perception. As a young doctor working on the dermatology wards I was asked to examine a young woman; the nurses were applying ointment to the psoriasis lesions on her naked body, and a weekly doctor's assessment was a routine task. I walked into the treatment room and started looking at the diseased areas. The patient tried to hide her nakedness, and the nurses did in fact wrap a towel around her waist, but I continued, making light of her embarrassment. With such a high belief in my own disinterestedness I thought her embarrassment was not warranted; in some way or other she should have known what was going on and trusted me to take only a strictly professional interest in her. I remember feeling mildly embarrassed at the thought that my actions might have been misinterpreted.

Looking back now, forty years later, I realise that any belief in the purity of my 'medical gaze' was beside the point: she was embarrassed, and that should have been attended to before examining her skin; I should at least have asked permission to enter the room. By discounting her feelings, and having such a high opinion of my own, it is clear that the 'medical gaze' had blinded me to what was important: the brisk pursuit of my duty had pushed moral obligation out of the picture. The moral failure lay in not anticipating her feelings and acting accordingly once her embarrassment became evident. This is offered as a modest but telling example of the uncoupling of professional duty from moral obligation, and I look back at the episode with regret.

I suddenly saw things anew after reading a similar episode in Tolstoy's *Anna Karenina.*[3] Kitty, the heroine, is suffering from love-sickness, an emotional disturbance; a specialist is called in for a medical opinion. The handsome young doctor insists on examining her. He thinks very highly of himself, dismisses her embarrassment on that basis, and finds nothing physically wrong, however his examination offends Kitty and her mother since he has not attended to her feelings. This episode is now subject to detailed academic study,[4] revealing Tolstoy's satire towards doctors, especially in their privileging of the external signs of disease over the internal state of the 'nerves'; they also reveal an interest in doctors' interactions with patients and their families, especially when they miss the whole point of what is going on, at least from the patient's perspective. Doctors are here shown to be unaware, and that is a moral failure made worse by their condescension, thinking of themselves as not just medical experts, but in a superior category of beings.

This thesis starts with a discussion of the mediaeval and modern foundations of the notion of supererogation. After centuries of neglect the topic came to life with the seminal essay by J. O. Urmson in 1958 and, more recently, a book by David Heyd opened up the topic to further description and analysis. The actions of the doctors who lost their lives to diphtheria are subjected to an imaginary scrutiny by a coroner, here focussing on motivation. The varieties of goodness and their relationship to the topic are described.

In the second part of the chapter the history of obligation as outlined by Aquinas is described. Supererogation had certainly been recognised by the early Christian fathers, linked with service to others at cost to oneself, and that led to much self denial and mortification of the flesh. St Jerome (347-420) epitomises much of this strain,[5] yet I look mainly at the work of Aquinas, especially *Summa Theologica* and *Summa Contra Gentiles.* Supererogation stems from the distinction he drew between precepts and counsels, the former required of all Christians, the latter required only of those

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3 Leo Tolstoy, *Anna Karenina,* (Oxford: Oxford University Press, 2016).

4 Valeria Sobol, *Febris Erotica: Lovesickness in the Russian Literary Imagination* (Seattle: University of Washington Press, 2009), 163-170.

5 In an early example of 'fight or flight' St Jerome fled to the desert to avoid temptation: 'Flight makes it impossible for me to win the victory; but at least it ensures me against defeat'. From *contra Vigliantium*; details are in K. E. Kirk, *The Vision of God The Christian Doctrine of the* Summum Bonum (London: Longmans, 1941), 254.

who chose to follow the more demanding path. This model, which I name the Beyond Duty model, has a two-tier quality, emphasising a vertical sense of hierarchy; much of that was centred on the division between manual work and the contemplative life, with the latter being held in higher esteem.

Chapter 2 is concerned with our basic obligations to one another and starts by asking what is required from us *ab initio.* By way of a thought experiment, a modern day *Dr* Robinson Crusoe finds himself alone on an island save for an injured man who, *per impossibile,* has also been washed up ashore as the sole survivor from another ship. I examine Dr Crusoe's responses, trying to think of what he might have done for his unexpected patient. This is complicated by the arrival of a third ship which has a doctor on board who has access to good medical facilities, thus introducing the biomedical model.

The nature of obligation as outlined by two recent philosophers, Bernard Williams and Alasdair MacIntyre, is examined, with special attention paid to the notion of the status in our lives of 'higher goods'. Williams was particularly critical of the limiting nature of obligations. I then imagine a newly appointed consultant doctor coming face to face with a strike in hospital and describe his actions and the thinking behind them. Of prime interest are the feelings of the doctor and the nature of his relationship with his patients. This raises more questions about the goods of medicine and how we should think about them.

It is of great interest how supererogation disappeared from view after the Reformation. In chapter 3 we see how supererogation came under fierce attack from the Protestant reformers, linked as it was with the corrupting influence of the sale of indulgences by the church. That was anathema to Luther and Calvin. For Catholics, supererogation had been the path to 'a lofty kind of life', as described by Kenneth Kirk, but for Protestants this became degraded into 'an additional duty' for Protestants.[6]

The philosophical changes in the early modern period are described, including Descartes and his promotion of rational, generalised views. A painting by

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6 Kirk, 520.

Rembrandt, *The Anatomy Lesson of Dr Tulp,* illustrates how professional development led to a detachment of doctors from their moral obligations. Aristotelianism also declined at this time, along with a sense of teleology, to be replaced with a narrower view of the passions in David Hume, Francis Hutcheson and Adam Smith.

The second part of this chapter looks at how behaviour changed in the eighteenth century, examining the standing of doctors as reflected in novels. This relates to published codes of practice, showing a cross-over in thinking between what was appropriate in doctors' behaviour at work and in society. This shows doctors carving out their own sense of duty from the amorphous block of claims pressing for attention. Supererogation does not enter into their published accounts of such duties; it had simply fallen out of view.

The 'dehiscence' of medicine is described, the gulf that had opened up between doctors and patients, and at how that was widened by professional changes including the development of clinics in hospital and the rise of Romantic medicine. Patients became objects of study to be fitted into philosophical and scientific frameworks. Following this generalised view, the next chapter focuses on individual doctors and patients to see how they fared as a result of the changes described above.

Chapter 4 is concerned with illustrations from literary sources, this time chosen from the nineteenth and the twentieth centuries. Not only are such sources rich in psychological detail but they have also been an inspiration for what we hope to find in doctors, especially in their attitudes to patients. Much of that is of course not easily discerned by doctors themselves, dressed or cocooned in professional codes of behaviour, and there is a perverse pushing away of the humanity of patients in order to focus on the medical condition or disease involved.[7] I am not simply claiming that reading novels makes us more thoughtful and sensitive to patients; rather, I make the stronger claim that doctors are often blind to what they are doing, and that this blinkered view is a failing of modern biomedicine despite its grand achievements. G. S. Rousseau pointed out forty years ago that while there are many publications

[7] I was struck by the odd language of the first obstetric case presentation which I attended as a medical student. The doctor said, 'The patient was successfully delivered of a live male infant'. In fact the mother had just given birth to a baby boy. Why say otherwise?

showing the influence of medicine in literature, the influence of literature on medicine had barely begun to be described. The balance needs to be redressed, and this is done by showing that literature can indeed improve medical practice.[8] The philosopher Martha Nussbaum points to the importance of the philosophy of literature, and the medical humanities contribute greatly to our understanding of what is going on in the medical encounter.

I look at Virginia Woolf's engagement with the medical world, her responses to the doctors she consulted and her portrayal of them in her novel, *Mrs Dalloway,* in which doctors fail in their approach to a patient who commits suicide.[9] This narrowing of views leads to harm when doctors are too confined by duty; there is a failure of imagination. The biomedicine of the present age proceeds on well-worn tracks towards a scientific goal, sometimes far removed from the notion of care; the harm done to patients sometimes seems like collateral damage in the pursuit of a goal chosen by the doctor for the advancement of medical science.

The second part of this chapter examines how doctors distance themselves psychologically from patients using a variety of techniques. These include: seeing the patient in a different category from themselves; distrusting the patient's account; intellectual detachment. I see condescension at the heart of these mechanisms; it is the most potent antidote to supererogation, signalling as it does a categorical difference between doctor and patient.

From the point of view of the onlooker, the Good Samaritan is a foundation for supererogation but the Sermon on the Mount (Matthew 5-7) points more to what is owing to the patient. We do not just attend to patients, they solicit our attention. Levinas was one philosopher who was aware of others calling to us in their distress. The turning point in this thesis occurs when doctors come to see patients in this new light, and partake of their suffering. I am recommending a deeper level of engagement, moving away from 'the interminable character of moral disagreements'. The Sermon on the Mount is an invitation for doctors to 'pick up the stick at the other end' in Wittgenstein's phrase, that is to grasp the vulnerability of patients and to pull

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8 G.S. Rousseau, 'Literature and Medicine: The State of the Field', *Isis,*72 (1981), 406-424.

9 Virginia Woolf, *Mrs Dalloway,* published in 1925.

them back up into health. Wittgenstein was concerned about seeing things *rightly*.[10] We are not mere spectators of our actions; the Sermon on the Mount invites us to share in the suffering of others. It is there that the right relationship is founded, not in the superiority of the doctor but on terms of modest acceptance that the doctor does not always know how medical knowledge should best be applied. Going hand in hand with this is for doctors to see themselves as patients in waiting, with their own suffering latent, postponed for the moment, leaving them fit enough for now to attend to the suffering before them. With this view of the importance of suffering the next chapter looks at an extreme view of this position, examining heroism in medical practice and how supererogation can be interpreted as self-sacrifice.

Chapter 5 thus moves away from the Beyond Duty model, with its clear demarcation between duty and supererogation. We now see if duty and supererogation can be brought together. The life of Dr Noel Chavasse (1884-1917) is examined closely. He was a doctor in the First World War who won two Victoria Crosses for heroic action in attending to the wounded. Though injured himself, he brought injured men back from the battleground and refused help until they had been attended to. His blurring of duty and supererogation leads me to see this model as more horizontal in essence, without any sense of hierarchy of the Beyond Duty model or of self-glorification; it is therefore in a different category from the first model.

This model does not encompass all examples of supererogation, and the sacrificial nature of it is very costly. In particular, supererogation does not have to be spectacular in nature; nor does heroism have to be obviously apparent. In chapter 6 a third model of supererogation is described; it is manifested by some present day doctors and it can be recommended. It is named 'Supererogation as Secular Sanctity'. I recommend it strongly for those doctors who are inclined to supererogatory practice. It is designed to alter our view of the concept and to leave us better able to face the suffering of patients without falling back on defensive modes of behaviour; importantly, it is less costly than the sacrificial model described in chapter 5. In this

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[10] 'Er muss diese Sätze überwinden, dann sieht er die Welt richtig'. Wittgenstein writes of recognising his propositions as nonsense and pushing away the ladder up which we have climbed, but these striking expressions perhaps disguise just how hard it is to see *rightly*. Ludwig Wittgenstein, *Tractatus Logico-Philosophicus,* trans. by D.F. Pears and B.F. McGuinness (London: Routledge, 2001), section 6.54, p. 89, Google ebook.

third model the view of supererogation described by Heyd is inverted, and his belief that supererogation is settled on a basis of duty is further challenged.

This model points our focus onto the roots of our relationships and views supererogation as arising from sympathy evoked by suffering. The philosophy of Iris Murdoch moves our thinking away from the Beyond Duty model towards a seamless engagement with the suffering of others. It epitomises an advanced aspect of medical goodness: the giving of oneself. The work of two doctors who came forward to help patients in extraordinary ways is described, and it seems that their own suffering opened them up to view their professional roles in this new light. The advantage of this model is that it permits doctors to practise in a supererogatory fashion without paying a very high cost. This model is therefore commended as the best of the three for medical practice.

The idea that doctors should embrace supererogation as an aspiration has been supported. By way of warning, however, we should note that doctors can get things badly wrong by failing to show wisdom and good judgement Two literary examples have been chosen to demonstrate the harm done to patients and to doctors' reputations when attempts at supererogation misfire. I look at *Madame Bovary* by Gustave Flaubert and *Middlemarch* by George Eliot. The doctors' failures are examined, with the conclusion that personal character flaws contribute to such misadventures. This points to the importance of the virtues and of character. In a nutshell, the doctor's gaze should continually be focussed on doing good for the patient; we have to work hard to overcome vanity and self-deception.

The concept of supererogation should be widely recognised in medical practice: the limiting nature of any list of prescribed duties should be continually acknowledged, and supererogation should be seen by doctors as a standing invitation to extend themselves in ever more generous ways. Supererogation will always strike an ambivalent chord, yet doctors would better face their responsibilities towards patients if they were at least aware of that ambivalence and came to think of it for themselves. The opposition to my views is acknowledged.

I hope this study, once accepted, would give doctors room for manoeuvre and permit a flexible approach to those patients who call for an extraordinary response. This study is designed to extend the repertoire of medical thinking.

In the final chapter we return to look at *Mrs Dalloway,* this time imagining a consultation between the patient, Septimus, and an actual doctor from the time the novel was written, Dr W. H. Rivers, who treated soldiers suffering from shell-shock with humanity and imagination. I predict what a different category of experience such a consultation might have brought about.

The work of Stephen J. Pope is outlined, especially his classification of our relationship with God. My third model of supererogation is equated with his 'incarnational view' whereby the distinction between personal and professional lives is blurred. For doctors drawn to this model of living and working, I foresee both satisfaction and emotional development, with a heightened sense of service towards others and spiritual reward for themselves. It is a difficult choice to make because it is costly in worldly terms, and so would not be for everyone; indeed this thesis is aimed at those doctors who are inclined to view their work in a broad and encompassing way.

In conclusion it is claimed that supererogation might be an optional requirement for doctors but one with distinct advantages. These are: firstly, a new way of extending themselves to those patients who need more than the 'business as usual' approach; secondly, the good chance that doctors' work satisfaction will increase; thirdly, that the insights gained from the study and practice of supererogation reflect back on the stringent requirements of duty so that doctors can view their service to others in an important new light.

A NOTE ON METHODOLOGY

This thesis takes as its raw material case histories, both real and imaginary, including literary accounts. In this sense I am working from experience, not trying to impose some theoretical framework on the texture of life. This approach is not anti-theory, rather it is based on the medical life as experienced by a practitioner. After retirement

from practice, I find there is a lifetime of experiences to draw on. My memory of those patients is mostly focused on subjective experience rather than 'the facts of the case'. This way of thinking was demonstrated at the bedside by Thomas Sydenham (1624-1689), 'the English Hippocrates', who was anti-theory, favouring direct observation at all times.[11] In philosophy this approach is demonstrated by Adam Smith who emphasises that rules are formed from our approval or disapproval of particular experiences, not the other way round.[12] In theology this approach is practised by Stanley Hauerwas who took as witnesses to the Christian life those 'lives that are lived'.[13] This approach can be extended to the characters in novels too, for their lives seem to be as transparent to the novelist's 'omniscient narrator' as patients are transparent to the doctor's 'medical gaze'. It should be noted that the medical gaze is not always benevolent.

This thesis cites those novels which, by remaining classics of literature, have demonstrated their permanent appeal to our understanding of the human condition. Ephemeral works of literature might focus brightly on the issues of the moment but without obtaining a lasting place in our hearts. Samuel Posen, who studied English before becoming a medical doctor, has compiled an extensive summary of the behaviour of doctors in over 600 works of literature. He describes authors' perceptions of the doctors they have created, including portrayals of their virtues and their many vices.[14] It is hoped that a close study of supererogation, by making us more aware, would tilt doctors in a virtuous direction.

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11 'I became convinced that the physician who earnestly studies, with his own eyes - and not through the medium of books - the natural phenomena of the different tissues, must necessarily excel in the art of discovering what, in any given case, are the true indications as to the remedial measures that should be employed.' Roy Porter, *The Greatest Benefit to Mankind A Medical History of Humanity from Antiquity to the Present* (London, Harper Collins: 1997), 229. Sydenham also advised students to read *Don Quixote* as one of 'the best medical books'.

12 'We do not originally approve or condemn particular actions; because, upon examination, they appear to be agreeable or inconsistent with a certain general rule. The general rule, on the contrary, is formed, by finding from experience, that all actions of a certain kind, or circumscribed in a certain manner, are approved or disapproved of.' Adam Smith, *The Theory of Moral Sentiments*, ed. by Knud Haakonssen (Cambridge: Cambridge University Press, 2009), 185.

13 Michael G. Cartwright, 'A Reader's Guide', in Stanley Hauerwas, *The Hauerwas Reader,* ed. by John Berkman and Michael Cartwright (Durham and London: Duke University Press, 2005), 637.

14 Samuel Posen, *The Doctor in Literature: Satisfaction or Resentment?* (Oxford: Radcliffe, 2005).

1. Chapter One: Ancient and Modern Foundations; The Beyond Duty Model

1.1 Introduction

In this chapter I describe what I will call the 'Beyond Duty' model, which we might see as the standard model of supererogation, and then proceed to show that its inadequacies mean that we need to start the search for a new model so that supererogation can be conceptually reframed. I describe the parable of The Good Samaritan because this shows both the 'dutiful' and the 'beyond duty' aspects, at least in traditional interpretations. In the first part of this chapter I also give an account of how the ancient topic of supererogation was brought back to life by J. O. Urmson in 1958,[15] and then further developed by David Heyd.

I give details of two doctors in Victorian London who exemplify this 'Beyond Duty' model: Dr Rabbeth and Dr Lucas, both of whom died as a result of attempting to save the lives of their patients. The memorial to Dr Lucas in The Middlesex Hospital, London, left a persistent impression on the author from his undergraduate years at The Middlesex Hospital Medical School (1970-1975), and this thesis is indeed some sort of testimony to many years of reflection on the event that took place on the wards of that hospital.

I explore the supererogatory element of their actions, i.e., their willingness to put themselves in danger to ensure the safety of their patients. The doctors were both praised and criticised for their actions, and this points to the ambivalent nature of doctors' views towards supererogation from their colleagues. In view of that ambivalence I then devise a scenario in which we focus not just on the actions of the doctors but also on their motivations. I imagine Dr Rabbeth facing examination in a coroner's court because of the fatal outcomes involved in these historical examples. I try to probe to the bottom of his thinking and motivation, for that after all is the foundation of action. I believe that a simple focus on action is inadequate to

[15] J. O. Urmson, 'Saints and Heroes', in *Essays in Moral Philosophy,* ed. by A. Melden (Seattle: University of Washington Press, 1958), 198-216.

understand both the concept of supererogation and its application. It is part of my claim that doctors focus too much on action and not enough on their intentions and aspirations, something which soon becomes apparent in attending case conferences and in reading clinical papers. They satisfy themselves with the fulfilment of their duties without pausing to think how such duties came to be formulated and accepted into common use.

In the second part of this chapter I look to the theological roots of supererogation as found in the works of St. Thomas Aquinas. The separation of precepts from counsels with regards to a Christian way of life had been developed centuries earlier,[16] in fact stemming from the distinction found in Matthew 19. 16-24, where life everlasting can be found by keeping the commandments, but perfection can be found only by selling 'what thou hast, and give to the poor, and thou shalt have treasure in Heaven'.[17] I begin with the Beyond Duty model in its modern guise, and then I discuss Aquinas who is credited with articulating the most memorable distinction between the two: precepts are applicable to all, but counsels are advisable for those who wish to pass beyond what is simply required and to attain greater levels of service to others at cost to our worldly selves. I see in this division the origins of what we now judge to be *reasonable*, in all walks of life, from what is excessive and uncalled for in ordinary circumstances.

1.1.2. Part One: The Beyond Duty Model

The name of this model stems from the division of morally good actions into those which are obligatory to perform and those which, though desirable, are not obligatory. This simple division can be attributed to one common reading of the Bible, in which the New Testament is contrasted with the Hebrew Bible. The Old Law valued dutiful obedience to established norms and procedures; the New Law valued going beyond that in new and imaginative ways. This is most noticeably declaimed in the Sermon on the Mount, where Matthew records Christ as saying:

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16 Kirk describes the writings of Optatus, Augustine and Fulgentius as early sources of the doctrine of supererogation. Kirk, 240.

17 David Heyd, *Supererogation* (Cambridge: Cambridge University Press, 1982), 17.

> Ye have heard that it hath been said, An eye for an eye, and a tooth for a tooth; But I say unto you, That ye resist not evil: but whosoever shall smite thee on thy right cheek, turn to him the other also. (Matthew 5. 38-39)[18]

This change of direction amounts to an invitation for us to leave ourselves vulnerable to the injuries inflicted by others, indeed an invitation to throw norms up into the air and see how they land afresh. It came to be interpreted as a range of Christian service, with a few people giving up the world for the sake of others, but with most not shaking off worldly ambitions but giving money and services according to the depth of their faith in accordance with their conscience. According to Matthew, the command of Christ is one of acceptance in faith, not by swearing oaths in a declamatory way, but in quiet acquiescence:

> Again, ye have heard it said by them of the old time, Thou shalt not forswear thyself, but shalt perform unto the Lord thine oaths: But I say unto you, Swear not at all; neither by heaven; for it is God's throne: Nor by the earth; for it is his footstool: neither by Jerusalem; for it is the city of the great King. Neither shalt thou swear by thy head, because thy canst not make one hair white or black; But let your communication be, Yea, yea; Nay, nay: for whatsoever is more than these cometh of evil (Matthew, 5. 33-37)[19]

This is about extending ourselves in ways which are not reciprocal, and we might see the kernel of supererogation in verses 46-47:

> For if ye love them which love you, what reward have ye? do not even the publicans the same. And if ye salute your brethren only what do ye more *than others*? do not even the publicans so?

Acts of supererogation might well redound on us in the form of praise and enhanced reputation, but such benefits are adventitious, for at the heart of supererogation lies the value of doing something for the sake of others, not for ourselves. I now go on to look at the Good Samaritan, for this parable shows the Samaritan serving another at cost to himself

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[18] All Biblical quotations are taken from the Authorized Version.

[19] The vain posturing with declarations of love and fidelity forms the dramatic opening of Shakespeare's *King Lear*. The king is so foolish that he believes the overblown declarations of his daughters Goneril and Regan, while disdaining the honest words of Cordelia. 'Love and be silent' are her watchwords, comparable to the 'Yea, yea' of Christ.

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The parable of the Good Samaritan is an illustration of helping someone who is not one of our 'brethren'. It appears to be a good example of the Beyond Duty model, for the rescue of the injured man is the dutiful part, while offering to pay the innkeeper whatever else might be needed corresponds to going beyond duty;[20] indeed it is the only example in the Latin Bible in which are the words, 'quodcumque supererogaveris'.[21] The parable can be read at many levels, a first reaction being the recognition of the notorious dangers of the road, something observed down the centuries and commented upon in our time by Martin Luther King when he drove from Jerusalem to Jericho.[22] Echoes of this attitude are found in the responses to the Postman's Park doctors, described below, who were criticised for not taking better care of themselves. The parable has been subject to allegorical interpretations, and a review of those put forward by the Church Fathers has been made by Riemer Roukema.[23] He describes how Augustine saw Christ in the Samaritan, while Origen interpreted the parable as an allegory of Christ in the world, with the victim as Adam, the Samaritan as Christ, and the innkeeper taking the role of the leaders of the church. Roukema also describes Calvin's suspicion of such elaboration; he preferred the simple truth as expressed in the gospel.

Attention to our neighbours is rightly 'hands-on'. Old master portrayals of the parable show a naked victim carried by a donkey, but propped up by the Samaritan. The painting by Aime-Nicolas Morot in the Petit Palais in Paris is perhaps the most touching in this respect.[24] The Samaritan is shown covered with the blood and sweat of the victim as they make their way to the inn. Rembrandt shows the story in an oil painting and in a later etching.[25] The etching shows the addition of a defaecating dog in the foreground, with the victim being lifted up from the donkey like a sack of potatoes. While there has been much speculation on the addition of the dog, with one

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20 Mark Wynn would describe the instructions to the innkeeper as an 'extended good of reason'. Mark Wynn, 'Supererogation and the Relationship Between Religious and Secular Ethics: Some Perspectives Drawn from Thomas Aquinas and John of the Cross'. *Supererogation,* ed. by Christopher Cowley (Cambridge: Cambridge University Press, 2015), 173.

21 Heyd, 17 (from Latin: 'any extra'. The modern Italian word, *erogare* means 'to provide funds').

22 From the 'I've Been to the Mountain Top' speech delivered the day before he died.

23 Riemer Roukema, 'The Good Samaritan in Ancient Christianity', *Vigiliae Christianae* 58 (2004), 56-74 (62).

24 He was awarded a medal of honour by his peers in the Salon des Artistes Français for this painting done in 1880.

25 The oil painting is in The Wallace Collection, London.

commentator seeing it 'as a symbol of the polluted life cleansed by the good deeds of such as the Samaritan';[26] the art historian Kenneth Clark commented that 'if we are to practise the Christian virtues of charity and humility, we must extend our sympathy to all natural functions, even those which disgust us'.[27] Attention to neighbours calls for a response at all levels of our humanity, and doctors must not be over-fastidious beyond a high standard of personal cleanliness which shows our respect for patients. I suggest that this cleanliness could be seen as a symbol of the psychological cleansing that doctors should undergo in order not to soil or distort the professional relationship. The loving willingness to get our hands dirty is at the height of our virtue; we then transcend self-regarding attitudes in the service of others, for the parable of the Good Samaritan turns the question on its head: not 'Who is my neighbour?', but 'How can I be a good neighbour to all?'

The parable is part of the teachings of Christ, and the respondent is a lawyer who asks, 'Who is my neighbour?'[28] We sense that he is trying to limit his liability, but Christ shows that legal limitations are no sure guide and that there is no cap on the costs our involvement might incur. The division into priest, Levite and Samaritan tells us of the surface dressing of others but not about their identity in the eyes of God. We can be stripped of such things, as the man was stripped of his raiment, and be left for naked and half dead. The parable calls especially to doctors because the man is not just naked but wounded; he needs attention, and the Samaritan binds his wounds with oil and wine. Here the Samaritan is stepping outside his societal identity; indeed the gospel of St John tells us that 'the Jews have no dealings with the Samaritans'.[29] The risk to himself was two-fold: firstly, a risk of being apprehended as the assailant of the man he was attending; secondly, a risk that the attack had been staged so that unwary passers-by could then be taken advantage of. Montaigne gives a vivid account of such fears in his essay, 'Of Experience'.[30] Such an account suggests self-protection

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26 Simon Schama, *Rembrandt's Eyes* (London: Allen Lane, Penguin, 1999), 413-414.

27 Kenneth Clark, *Rembrandt and the Italian Renaissance* (London: John Murray, 1966), 12. The author has brought these images to mind while performing manual evacuation of faeces on patients at home (usually debilitated old men) who were so severely constipated as to be in great pain and distress. It is important for the patient and the family that the doctor does not express any sense of disgust at what he is doing: 'It's all part of a day's work'.

28 Luke 11. 29. 'But he, willing to justify himself, said unto Jesus, And who is my neighbour?'

29 John 4. 9.

30 'Some countrymen recently informed me in great haste that they had just left, in a wood that belongs to me, a man with a hundred wounds, still breathing, who entreated them for pity's sake to give

trumps putting ourselves at risk for the sake of others, and this attitude, sensible and worldly, is in accord with the idea that our obligations one to another are not open-ended but are normally muted and held in check.

In summary of this section so far, we can see that the Beyond Duty model seems straightforward enough on first encountering it, but the Sermon on the Mount is a challenge to our comfortable notions and the norms we live by. The Good Samaritan also shows this simple division being subverted when we examine our responses in the light of being good neighbours to all.

I have outlined in rough draft the Beyond Duty model, but at this stage we can say that so far it amounts to a just a work in progress. I now wish to demonstrate how these ideas were transformed into a modern, secular setting.

1.1.3. The Modern Start: Urmson's Seminal Article

J. O. Urmson began the modern debate in a 1958 article, *Saints and Heroes*.[31] His aim was not to rehabilitate an old concept, but to challenge the usual tripartite division of moral actions into the obligatory, the permissible and the wrong. He introduced the notion of a fourth category of actions which are morally desirable but not obligatory, and he used examples of a doctor (the 'saint') and a soldier (the 'hero'). This fourth category came to be called 'supererogation'. Urmson had been decorated for his courage in the Second World War, and possibly this shaped the clarity of his distinction between what can ordinarily be expected and what the hero or saint might achieve. Urmson contrasts two doctors to illustrate what might be achieved by a saint: the first, 'who does his duty by sticking to his patients in a plague-stricken city'; the second, 'who, no differently situated from countless other doctors in other places, volunteers to join the depleted medical forces in that city'. The first shows a 'saintly self-discipline in the way of duty'; the second shows 'the dedicated, self-effacing life

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him water and help him to rise. They said they did not dare go near him, and ran away for fear the officers of justice might catch them there, and (as happens with those who are found near a murdered person) they should be made accountable for that mischance, which would be their undoing, since they had neither the ability nor the money to defend their innocence. What could I say to them? It is certain that that act of humanity would have brought them into trouble'. Michel de Montaigne, *The Essays of Montaigne,* trans. by E. J. Trechmann (London: Oxford University Press,1927), ii, 546.

[31] Urmson, 198-216.

in the service of others which is not even contemplated by the majority of upright, kind, and honest men, let alone expected of them'.[32]

Urmson gives the impression that he is having to reclaim this category of moral actions from the encroaching influence of earlier philosophers: for utilitarians like G. E. Moore such acts of heroism and self-sacrifice fell within the category of duty, and so such heroic actions were ordinarily required; for Kant, similarly, all was subsumed within 'the categorical imperative of duty, and every duty is equally binding on all men', and so there was no separate space for saintly actions.[33] Urmson was at pains to create a separate compartment for these actions, though not, it must be said, by devaluing duty; indeed he perceived that a strong argument for creating such a new category was the influence of J. S. Mill who believed that carrying out our duties was akin to paying our debts, while noble acts of self-sacrifice could not be seen in that way. No blame attaches to not doing a supererogatory act, while of course derelictions of duty are condemned. Urmson also states that if we were somehow to include saintly acts within the realm of duty, then that would 'lower the degree of urgency and stringency that the notion of duty does in fact possess'.[34] In that I see the nascent state of the Beyond Duty model, for Urmson draws up a list of grounds to distinguish 'basic rules' from 'the higher flights of morality'; he also admits that supererogatory acts, though optional, might be 'equally pressing *in foro interno*' as dutiful acts, [35] and to me that indicates the simple, one-on-top-of-the-other nature of duty and supererogation in this Beyond Duty model.

In 1988 Urmson retracted the term supererogation; he did not like the emphasis on the now four-fold classification which he had unwittingly introduced. He distrusted over-neat categorisations which forced a schema onto the complexity of life. Nevertheless, with his confident assertion ('on the whole the best philosophy is little affected by theory; the philosopher sees what needs doing and does it'),[36] and the attractively bold title, *Saints and Heroes,* he did in fact stimulate many responses.

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32 Urmson, 201- 202.
33 Urmson, 206.
34 Urmson, 212.
35 Urmson, 215-216.
36 Obituary, 'Professor James Urmson', *The Telegraph,* 4 April 2012.

I have discussed Urmson's tentative proposals, and now I introduce one of the leading contributors to the understanding of this concept.

1.1.3.1 David Heyd

In our understanding of supererogation, David Heyd is especially important because of his book, *Supererogation Its Status in Ethical Theory*.[37] According to Heyd, supererogation is best understood first of all on the basis of the fulfilment of duty. Secondly, supererogation goes beyond duty into the realm of what is desirable but optional. We therefore can see his model as the clearest example of the Beyond Duty model, with emphasis on the fulfilment of duty followed by something morally worthwhile in addition. Though Urmson linked supererogation to duty in his prime examples, it was Heyd who elaborated this division into a complex whole. His distinctive argument is that the relationship across that border is sustained by the terms of *correlativity*, i.e., supererogation derives its meaning from obligation, and *continuity*, i.e., supererogatory acts are as morally good as the obligatory action on which they build.[38] He points out that although clearly related to duty there are serious difficulties in finding a home for the concept within moral theories: virtue based theories do not recognise duty and so cannot distinguish duty from all the other good things we might do; utilitarianism judges that morally good actions cannot be thought to be non-obligatory, and furthermore that they can be ranked in order of utility; even deontological theories, especially the stringency of Kant, seem to push all actions of moral worth into the realm of obligations. The contract theory seems the most promising: it is based on justice, and with its minimal notion of moral duty leaves scope for optional moral behaviour on top of that.[39]

An illustration which supports this Beyond-Duty aspect would be the case where a commanding officer asks for volunteers for a mission. There is clear danger, and so the officer does not feel able to order any soldier to do it. After a delay some soldiers do come forward and the mission is undertaken. Here the mission is in a separate

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37 David Heyd, *Supererogation Its status in Ethical Theory* (Cambridge: Cambridge University Press, 1982).
38 Heyd, 5.
39 Heyd, 92.

category from duty yet is contiguous to it. The soldiers know that if the mission is vital then the officer is going to wait for as long as it takes for *someone* to come forward, and the assumption is that *someone* will eventually give way, for if all refuse then the whole group would suffer a loss of esteem. I believe such an example shows how supererogation can be seen to stand alongside duty, and so the two categories are related like brothers or sisters. Indeed the Beyond Duty model does seem applicable when supererogatory acts stem from duty, and the majority of modest examples of supererogation do seem to be closely related to duty. This view is favoured by the fact that some acts can be interpreted as either duty or supererogation, sometimes with our taking differing views on succeeding days. In my second hospital 'house job', I arrived to find a large pile of patients' notes for which discharge summaries had not been sent to the GP. My predecessor should have done them. I was asked to do them, knowing nothing of the patients concerned and struggling to read the doctors' writing. I did in fact do what was asked but felt resentful about it.[40] On some days I could soften my attitude by thinking that such things could arise in busy surgical departments, and that change of attitude, seeing something worthwhile instead of feeling imposed upon, helped me to do it with a better grace. I found that I could see the work sometimes as a duty, sometimes as beyond my duty, and this again illustrates the close affinity of *modest* acts of supererogation and duty.

What is that distinguishes duty from the performance of supererogatory acts? I suggest that the latter are motivated by the virtue of generosity. The notion of duty is treated by Adam Smith and by David Hume as something which is subsumed by the virtues, with duty performed from the simple observation of 'general rules of conduct', all done 'very decently'.[41] But Smith claims that duty is not enough and that something more is required:

> That the sense of duty should be the sole principle of our conduct, is no where the precept of Christianity; but that it should be the ruling

[40] Hauerwas describes how coping with our resentment is perhaps the central challenge of the Christian life: 'I suspect that one of the reasons growth in the Christian life is described as conversion is that it requires us to learn to live without resentment'. Hauerwas, 'The Christian Life' 247.

[41] Smith, *TMS,* 188. Hume gives the example of two oarsmen who row a boat by 'common convention for common interest, without any promise or contract'. Duty to each other is not mentioned. David Hume, *Enquiries Concerning Human Understanding and Concerning the Principles of Morals* (Oxford: Oxford University Press, 1988), 306, number 257.

and the governing one, as philosophy, and as, indeed common sense.[42]

What is the relationship between duty, supererogation and the *telos* of medicine? I suggest that acts of supererogation point doctors towards the fulfilment of the *telos*, although we might fall short of that and settle on intermediate goals instead (this aspect of change, understanding intermediate goals for what they are, needs to be handled wisely).[43] What we can note here is that for Aristotle and Aquinas the *telos* of an activity remained fixed. What does change is the expression of the manners and virtues and knowledge of doctors. I am here acknowledging different opinions on the nature of the *telos* of medicine. MacIntyre believed that goals are shaped by the history of the practice as applied by experienced practitioners. This was contested by Janet Coleman who claimed, in her study of Aquinas, that, 'What being a doctor is is not determined by a historical tradition of practitioners but by the definition of doctor.'[44]

In this regard I claim that the *telos* of medicine should be firmly focussed on the care of the patient (and not primarily the cure of disease, for that supervenes on care), here differing from Coleman.[45] I am making this point because it is the *telos* which gives us a fixed goal, and if it were kept in mind then doctors might be able to find imaginative solutions to the problems of ill health, something more expansive than the basic performance of duty.

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42 Smith, *TMS,* 199.

43 'When presented with an ascent to the unconditioned, with Platonic strains, it is important always to hold in mind that penultimate goods need not be regarded as unimportant as such, and certainly not as pernicious. Rather, the point is that they do not have the unlimited and unconditioned importance of being our final and all-satiating resting place'. Christopher Insole, *The Intolerable God, Kant's Theological Journey* (Grand Rapids, MI: Eerdmans, 2016), 142.

44 Janet Coleman, 'MacIntyre and Aquinas', in *After MacIntyre, Critical Perspective on the work of Alasdair MacIntyre,* ed. by John Horton and Susan Mendus (Cambridge: Polity Press,1994), 70-71.

45 'he who uses his knowledge to cure the ill, bringing them back to health where possible'. Coleman, 82. It might seem immaterial to claim the telos is either the 'cure', or the 'care' or 'the health of the patient's body', but these variations do, I suggest, point us in somewhat different directions.

1.1.4. Objections to the Beyond Duty Model

I have examined the Beyond Duty model and now wish to point out three main objections, especially in view of the expansive nature of our service to others which I have just recommended. Firstly, Joel Feinberg pointed out a problem with this new category soon after Urmson's publication.[46] The problem lay in seeing moral obligations as being too readily understandable in legal terms, in so-called 'house rules'. Urmson's approach was apt to label supererogatory acts as 'duty-plus', that is, in the satisfaction of our duties with some more thrown in for good measure. This approach is satisfactory for those jobs which are indeed defined in terms of lists of duties, such as the example of the janitor Feinberg used as an illustration, where it is soon apparent when the duties have been completed, but it does not satisfy the realm of actions which are desirable once duties have been fulfilled. Feinberg distinguished between what we *ought* to do independently of the obligations and duties of our employment. The latter can be known by looking up our contractual duties or by 'asking the boss', but the former demands more from the agent than can be specified in advance. Feinberg then finished his article with an unresolved comment: does 'moral worth' stand for the respect and satisfaction of rules or does it stand for something over and above that - for 'final human worth, all things considered'. That choice is at the heart of our difficulties in understanding supererogation and is further explored in the chapters to come, although I state now that the concept of supererogation, especially as it applies in medical practice, cannot be fully captured by this simple idea of 'duty plus a bit extra'. The main point of contention is that the Beyond Duty model focuses on duties arising from contractual employment and professional standards, but moral obligations are independent of our contracts and professions, and these might be lost sight of when doctors are so busy at work.

Secondly, the main fault of this Beyond Duty model lies in the notion of a scale of giving being transmuted into a much cruder either/or way of thinking. This might spare the purses of most of us - for example, rescuing the man yet not paying the innkeeper - but at the cost of a blunting of our moral responsiveness, leaving us obtuse to the sufferings of others. It is clear that simple divisions cannot be made

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[46] Joel Feinberg, 'Supererogation and Rules', in *Doing and Deserving, Essays in the Theory of Responsibility* (Princeton, New Jersey: Princeton University Press, 1970), 3-24.

except in those clearly defined, contractual roles such as the 'janitorial' roles described by Feinberg: doing 10 hours work for 8 hours pay is clearly a supererogatory action in this straightforward manner.[47] But not all actions can be viewed in this binary way; for example, St Luke 6. 30 points to the open-ended nature of our giving to others, and in St Luke 18, as mentioned earlier, 'a certain ruler' is enjoined not simply to follow the commandments but to 'sell all that thou hast, and distribute unto the poor, and thou shalt have treasure in heaven'. That points to the limitless nature of our service to others, something far removed from the 'duty satisfied, job done' aspect of ticking off a list of duties.

Thirdly, Feinberg also points out a subtle and more serious objection to the Beyond Duty model; that is the 'conceptual aggression' that occurs when we allow the 'institutional' aspect to overshadow the 'non-institutional aspect'. An example would be where the work-related examples push out those examples where a contract of employment has no bearing; the overtime worked by the janitor, for example, comes to be conflated with the actions of the saintly doctor. He warns of trying to force too many instances into one model:

> Thus the philosopher's natural partiality for the familiar leads to a distinctive sort of conceptual aggression. As a consequence of this failure to observe conceptual boundary lines, a contrast essential to both distinguished concepts disappears. The effects here as elsewhere are misleading and bizarre [. . . .] Then, having made this tidy Procrustean bed, the philosopher is obliged to try to jam into it the unsolicited services, gifts, and favours, the saintly and heroic feats, the meritorious, abnormally risky non-duties.[48]

I suggest that this compression of diverse elements onto the Procrustean bed amounts to a further example of 'Loss of Problems', here shown by an impoverishment of conceptual thinking rather than a misunderstanding of the more normative aspects. The difficulty lies in accommodating saintly actions into the Beyond Duty model: they seem forced into whatever space is available and become distorted and bent out of shape.

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47 Feinberg, 9.
48 Feinberg, 20.

We can thus portray the complexity of supererogation and the difficulties we face in applying it satisfactorily. Firstly, an over-simple division obscures the complexity of a doctor's lived experience, and this again points out deficiencies in the Beyond Duty model. I find that in acute situations there is no clearly felt distinction made by doctors as to the boundary between duty and supererogation, and this fact introduces for us something that is essential for this thesis to succeed. Studying our duties from afar, we can see that duties can be seen on one side of a divide, with supererogatory actions on the other: a 'job-description' points us in that complacent direction. But once at work, face to face with pressing concerns, then such a division breaks down. We get drawn in, obviously so with the emergencies which arise, but even in ordinary consultations we find ourselves called upon to show deeper qualities of ourselves. Medical practice is a test of character just as much as skill, something which has perhaps been lost sight of in modern biomedicine. The sense I am trying to capture here is the feeling that supererogatory acts sometimes do correlate with duty, as Heyd points out, but at other times they become detached from duty and float free of their own volition. This aspect also underlines the weakness of the Beyond Duty model.

1.1.5. The range of supererogation

A further complex factor is the disputed range of supererogation, especially in its psychological aspect. The topic has been raised by Heyd who distinguishes between the actions of a doctor in a professional capacity and the actions of the person who, we might say, just happens to be a doctor. It constitutes a difficult section, especially noteworthy as he uses a medical example, echoing the example used by Urmson. In describing the actions of a doctor who 'goes to a plague-stricken city', even though it is not his duty to do so, Heyd comments that,

> The supererogatory element in his praiseworthy act lies not so much in his action *as a doctor*, but rather in his action *as a man* (who happens to have a highly relevant skill).[49]

For Heyd the characteristic of supererogation is that it lies '*beyond* duty', and that it centres on natural duties of person to person; furthermore that natural duties might

[49] Heyd, 135.

well diverge from any 'institutional duty *as a doctor*'. He goes on to state that 'supererogation is correlated to natural, non-institutional positive duties of man qua man'.[50] That specificity seems to be a stringent restriction of the concept to largely non-professional roles, bringing into doubt the exact nature of the actions of the doctors described above. It is important for the continuation of this thesis that we look at this now. In order to illustrate the issues, let us look closely at two historical doctors who died as a result of trying to save the lives of children they were operating on.

1.1.5.1. Postman's Park

In view of the complexities described above, I now describe the actions of two doctors which illustrate the Beyond Duty model, at least at first reading. Near St Paul's Cathedral in London, at the small public garden known as Postman's Park, lies the Memorial to Heroic Sacrifice. It was proposed by the artist and sculptor George Frederick Watts in 1897 and consists of ceramic memorial plaques covered by a loggia. Two of the plaques describe heroic actions of young doctors; they were unrelated to each other, but both died as a result of contracting diphtheria from patients whom they were attending. The first is inscribed to 'Samuel Rabbeth Medical Officer of the Royal Free Hospital who tried to save a child suffering from diphtheria at the cost of his own life October 26, 1884'. The second is inscribed to 'William Freer Lucas M.R.C.S. L.L.D. at Middlesex Hospital Risked poison for himself rather than lessen any chance of saving a child's life and died Oct 8th 1893'. Rabbeth was performing a tracheotomy operation to allow the child to breath through a hole made in the trachea; he applied his lips directly to the tube to suck out the airways and died as a result of the infection. Lucas was also performing a similar procedure, was sprayed on the face by infected matter from the child's airways, but did not pause to wipe his face clean before continuing the operation. He died too. I wish to look at the actions of the doctors and how they can best be described, and also to discuss how well the Beyond Duty model matches up to their actions. By so doing I aim to demonstrate the motivations of the doctors

[50] Heyd, 120.

The difficulty is as follows. If their duties were to do whatever was necessary to save the children, then they may *not* have acted supererogatorily because they were still acting within their professional role. If they had somehow stepped outside that role and were acting as anyone might want to help a child in distress, then they were acting supererogatorily, even though the way they could help those children in those circumstances was to act just as they did, simply because they had the necessary skills to do so, disregarding their own safety to concentrate on them. It might help to clarify matters if we put ourselves in the shoes of other people present during these operations. A theatre porter looking on might have had just as much desire to save the child's life. We can imaging him wanting to help but not being able to do so because he lacked surgical skills. This makes the point that the doctor and the porter could have had the same motivation to save the child, but that the one could not do so because of lack of skill, even though he was willing to step beyond his role as a porter and act, as Heyd describes, as '*man qua man'*.

The important and difficult point is that actions can be described in different ways, and indeed the doctors' actions were both praised and criticised by their contemporaries. Just as the concept of supererogation seems to be multifaceted, so each medical act can receive different interpretations. Dr Rabbeth was criticised for not obtaining a mechanical sucker beforehand, and wonder was expressed at Dr Lucas for not wiping his face or wearing a mask, notwithstanding that both men were praised for their courage. Emergency interventions can be described as steering a course between reckless, possibly culpable, self-exposure to danger on the one hand, and courageous and resolute determination to do whatever is necessary to save life on the other hand.[51] The tension between these opposing points of view reveals something important: supererogation might emanate from duty as Heyd describes, but then it seems to become peculiar and odd; it just does not sit happily on the foundation of duty and cannot be fully grasped by that concept.[52] We might agree that supererogation *correlates* with duty, as he describes, and that seems true for modest examples, but it does not *cohere* with it. Supererogatory behaviour could be seen as inefficient or reckless, but if done from a good motive, it transcends such

[51] Perhaps that *post hoc* calculation shows how prevalent is our leaning towards utilitarian critique.
[52] A dentist can cement a crown onto the roots of a tooth, but without full reciprocity between the crevices to be joined then the bite is uncomfortable.

criteria and passes into a higher or different realm where such questions are set aside; though we must deploy a certain finesse and be aware of imitations, e.g., the so-called 'apparent altruism', described by Von Wright.[53] Supererogation thus remains vulnerable to charges of recklessness derived from the world of efficiency.

In summary so far, it can be seen that although supererogation rests on a basis of duty in this Beyond Duty model, nevertheless there are serious difficulties laying down the concept on such a foundation. Put bluntly, and in agreement with Feinberg, supererogation cannot be fully captured by this sense of 'duty-plus' for the following reasons: firstly, it is insufficiently attentive to the richness of described examples; secondly, it leaves acts such as volunteering adrift without the foundation of duty to support them; thirdly, it is only helpful in those 'cold' cases where we do not feel impelled to act beyond duty but calmly choose to act in a manner which goes beyond the usual; fourthly, it cannot fully describe those cases when we are swept up by events. Such events are commonplace in medical practice, and those doctors who try to stay well clear of such things might be doing an injustice to their patients and to the development of their own characters. In other words we cannot always judge beforehand what our duty consists of, and we need to be mindful of what our moral obligations require, independent of our professional requirements. If we do not acknowledge that complexity then that failure in itself would be part of the 'flattening' of response described by Wittgenstein in his 'Loss of Problems'.

1.6.1. Dr Rabbeth forensically examined

Let us stick with that complexity by looking at Dr Rabbeth in some detail to see if such scrutiny throws light on the nature of supererogation. The absence of detail permits such an experiment, so let us imagine that he survived the diphtheria which he had contracted from the patient, but that the child died. How might he have responded to an examination by a coroner? I am looking at this in the light of the

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[53] We should be aware of the imitations of supererogation, e.g., 'Apparent altruism, on this view, is always egoism in disguise'. G. H. von Wright, *The Varieties of Goodness* (London: Routledge & Keegan Paul, 1963), 185.
'But what was his motive for doing the "something more"? It may have been from a mere whim or fancy - in that case we certainly do not praise him; and if the matter is a grave one he is even to be blamed for treating it in a flippant spirit'. Kirk, 522.

arguments gathered together in *Reason in Ethics* by Stephen Toulmin and described below.[54] Toulmin models how to obtain clarity in decision making. The questions might have been as follows:

Firstly, let us follow a dialogue between the coroner (C) and Dr Rabbeth (R) which might be called, ***The Call of Duty:***

C. Why did you not make sure you had a mechanical sucker at the start of the operation?
R. I thought we had one in theatre, but it had been taken out for another case.
C. And was the lack of the sucker the reason you applied your mouth to the child's neck and sucked out the airway as you did?
R. Yes, Sir.
C. Knowing that such an action would put your own life in danger?
R. Yes, Sir.
C. Why did you put your own life in danger? Was that not going beyond the call of duty?
R. Well, Sir, having gone so far with the procedure I believed it was my duty to do whatever was necessary to clear the airway.

Now let us imagine an alternative pathway, ***The Call of Supererogation:***

C. Why did you put your life in danger? Was that not going beyond the call of duty?
R. Well, Sir, it did seem to me to be beyond what might have been expected, something beyond duty. I suppose I was just acting as myself, not so much as a doctor but as anyone might have done.
C. How was that?
R. Because of the seriousness of the situation. The child was on the point of asphyxiation.
C. Could you not have waited for a second sucker to be found?
R. No, there was no time.

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[54] Stephen Edelston Toulmin, *An Examination of the Place of Reason in Ethics* (Cambridge: Cambridge University Press, 1961).

C. And so you were willing to exceed your duties and put your own life in danger?

R. Yes, Sir, I suppose so.

C. Why was that?

R. Because the child's life was worth saving.

Toulmin would name such a final question from the coroner, 'a limiting question', that is one to which no further reason can be found. The doctor's final comment represents a 'gerundive' concept, that is, something removed from the world of credibility and plausibility, concerned instead 'with concepts of a *different* kind'.[55] The child's life was beyond price, above and beyond any calculative way of thinking. At one level, when reasons 'give out', we sense that no further search for deeper explanations is going to be fruitful; at another level we sense that any search for a bottom of things is futile, representing the limitations of propositional knowledge. This is similar to a musical modulation from one key to another; there is a sudden change of mood and we feel we are in a different place. The musical analogy fails because there usually follows a modulation back to the original key, bringing a welcome sense of returning home, but there is no such relief in philosophy. Wittgenstein was keen on the idea of a bedrock beyond which no further excavation can be made: 'If I have exhausted the justifications I have reached bedrock , and my spade is turned'.[56]

Let us imagine a third exchange in the coroner's court, this time looking on the practical exigency of the case; this third pathway is named, ***Doing what needs to be done:***

C. Why did you put your own life in danger for the sake of the child?

R. Because the circumstances required it.

C. Although your action was commendable, did you not think your action was somewhat reckless? Your duty did not require you to put your own life in danger.

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[55] Toulmin was suggesting that plausibility is not enough: 'the argument itself must be *worthy of* acceptance, as making its conclusion *worthy of* belief.' Toulmin,71. Also Toulmin, 204 for the form of argument illustrated in the text above.

[56] Carl Elliott, 'Introduction: Treating Bioethics', in *Slow Cures and Bad Philosophers, Essays on Wittgenstein, Medicine, and Bioethics,* ed. by Carl Elliott (Durham: Duke University Press, 2001), 4.

R. I just did what had to be done. I wasn't thinking in terms of duty nor of going beyond duty, none of that came to mind. The airway was blocked. I just did what needed to be done. What else was there to do?

This third exchange gets to the heart of the matter. It is similar to the second exchange in that reasons for action give out and then instinctive courses of action are taken. It is done perhaps on the spur of the moment, with reasonable justification only being thought about *after* the event. The two exchanges sound similar, however the second portrays the doctor exceeding and then leaving behind the notion of duty, while the third dialogue portrays the doctor not being inclined to see his actions from within that framework. In fact the third dialogue suggests a sense of duty being left out of the picture; it has no traction on the doctor as a force pushing him from behind, rather he is pulled forwards by the needs of the patient directly before him.

This ex post facto justification of our actions is indeed a common feature of evidence heard in a coroner's court, and a further indication of the way we run out of reasons. What is going on at such moments when we run out of intellectual steam? Toulmin tells us that,

> 'Moral principles' carry us only so far: it is only rarely that we can go all the way with their help. And when their job is done, the harder task remains of seeing the right answer to a question beginning, 'If you were me [. . .] '[57]

Although Toulmin is speaking at one remove from the world of what to do with the patient before us, in his more abstract search for such changes of perception as occur in human affairs, we can see that the second and third dialogues show the move from actions based on duty to actions based on generosity and a sense of standing alongside people in danger. This can be lost sight of in court, but it is then, as Toulmin states, that 'the agent's "feelings" and "attitudes" enter in, not as the cardboard creatures of philosophical theory, but as logically indispensable participants'.[58]

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57 Toulmin, 158.
58 Toulmin, 158.

All this suggests that at the heart of the matter Dr Rabbeth is going beyond professional duties, or rather putting them to one side. He accepted the intimate nature of his service to his patients - taking pus into his mouth from the airway of the patient - just as the Good Samaritan would have been covered with the body fluids of the victim: they might have flinched from these encounters but they carried on. So while on the face of it these two doctors could be understood as examples of the Beyond Duty model, in fact under careful scrutiny, we can see that they had adopted a different approach. I claim that they shared the vulnerability of those they were helping because they had entered into a relationship which called for them to let go of their own safety and to leave themselves vulnerable for the sake of their patients. Seen in this light they were not acting beyond duty; rather, if anything, they seem to have been acting 'underneath' duty, leaving behind the formal duties of doctors as might have been demarcated by professional codes of behaviour, and responding more on the level of fundamental, tacit obligations, the diffuse, inchoate responsibilities we have for each other. Usually the professional duties doctors put into practice serve to limit their commitment towards patients, with the unfortunate result that the tacit obligations become subsumed or pushed to one side by the hegemony of professional duty.

1.1.7. A Porous Boundary

The Good Samaritan shows that others are always calling to us in their distress. How far we should go in response is an open question. Whether we regard their distress as an integral part of our humanity, or as something independent of us and only contiguous to us, is indeterminate. In fact in practice we sometimes respond, sometimes not: when we do then the distress of others penetrates into us; we incorporate their suffering into ourselves, perhaps more so as we grow older and have the maturity to permit our defences to slacken and decay.[59] I am suggesting that this is at the heart of the matter in the case of Dr Lucas and Dr Rabbeth. Both doctors' actions point to a going beyond morality in the sense of any calculation or self-justification of their actions in the light of moral theories. Dr Rabbeth especially

[59] 'The soul's dark cottage, battered and decayed, Lets in new light through chinks that Time hath made' From *Old Age* by Edmund Waller (1606-1687).

accepted the intimate contact of his service. Indeed much might be written about how doctors respond to the intimacy of the *bodily* patient in front of them.[60] The instantaneous nature of their response is what strikes me most, an unformulated response.

The unformulated indeterminacy for doctors is shown in a common example. Driving along we come across a hold-up; the traffic slows down and we crawl past the scene of an accident Cars have collided and there is debris on the road; the drivers are on their phones and do not appear to be attending to injured passengers. Does the doctor pull up further ahead and run back to see if she can be of help? Bernard Williams is sympathetic to doctors in such situations.[61] I now list some responses, all jumbled up, like a stream of consciousness in James Joyce's novel, *Ulysses* (1918-1920):

can hear an ambulance?; didn't see any blood; was someone on the ground?; always going too fast; nowhere to stop; is it my duty?; should I?; no one unconscious; no good without my medical bag; what's in the boot?; keep his airway open; first-aid bag; over the limit I expect; never anywhere to stop on this road; thank God there's a siren.

The responses flash through our mind and then suddenly we are too far on the road to actually pull up and walk back to the scene. We continue on our way, trying to ignore any nagging doubts. What factors might make us stop and offer to help? These might include: no other cars about; a remote, quiet road far from town; obvious distress; shouts for help; people flagging us down; body through windscreen. The factors which keep us on our way include: police on scene; paramedics packing up their equipment; drivers looking at their bumper bars; passengers and children in our own car.

We passed by on the other side, that atavistic aversion to getting involved for fear of trouble, but this is disquieting, or should be so, Nor can our reasons stand up to the

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[60] David Hartley, FRS, (1705-1757) wrote *Observations on Man, his Frame, his Duty, and his Expectations* (1749). A doctor and philosopher, much of his philosophy seems to have stemmed from his feeling the heat, pulsation, and the distressing 'vibrations' of his patients at the bedside. He outlined the philosophical movement named 'Associationism'.

[61] 'What counts as being confronted is a real question, and a very practical one for doctors in particular'. Bernard Williams, *Ethics and the Limits of Philosophy* (London: Routledge, 2006), 244.

evidence. Even though we only glanced at the scene in passing yet we tell ourselves there was no need to stop. With wishful thinking we persuade ourselves that everything is alright. Even when we override our doubts we know we might have got it wrong - there might have been a passenger on the back seat, unconscious with a blocked airway, whose life might have been saved simply by holding her chin forward. So it is often wrong to override our doubts; it is false to comfort ourselves on insufficient evidence. Such thoughts should trouble us, for if we had stopped then we would have eventually continued with peace of mind. Avoiding the inconvenience can sometimes only be obtained at the cost of regret and guilt, and staving off such feelings can be the work of a lifetime. Momentary decisions can have long-term consequences.[62]

Should a doctor always stop? That depends on how we see duty and how we divide it from supererogation. The notion of duty is open to nuanced interpretation. We might never stop, thinking bluntly that it is none of our concern; we might stop sometimes, depending on how busy we are, how we feel, how bad is the traffic. We might act idiosyncratically, or we might have a wide remit for our sense of duty and always stop, thinking that such an action would be just what is called for. That would be an example of the 'general obligations' described by Richard Swinburne, where we can prevent great harm by taking simple steps of intervention.[63] This in turn calls for good judgement as to what 'simple steps' amount to; perhaps the slower we are travelling the greater the need to stop - we are more 'on scene', a player in the drama.[64] If someone at the accident recognised me then I would be more inclined to stop, fearful of reputational damage.[65] Very often it seems as if reasons are thought of after the event, and I now illustrate this in the following example.

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62 In Thomas Hardy's novel, *The Mayor of Casterbridge*, Henchard gets drunk and 'sells' his wife at a country fair. The tragic consequences lead to his disgrace and death.

63 Swinburne give the example of picking a person out of the water if we are passing in a boat, and he cites James S. Fishkin who calls this the principle of minimal altruism. Richard Swinburne, *Responsibility and Atonement* (Oxford: Clarendon Press, 1989), 21. James S. Fishkin, *The Limits of Obligation* (New Haven: Yale University Press, 1982).

64 Bernard Williams thinks that there is no obligation 'to go round looking for people to assist'. but passing the scene of an accident, especially when walking past, draws us in. Williams (2006),181.

65 The reflexivity of moral obligations is triggered by fear of loss. Bernard Williams writes of the internalisation of 'reciprocal attitudes'. Bernard Williams, *Shame and Necessity* (Berkeley: University of California Press, 1997), 83.

Good Samaritan acts are beyond reason but not irrational. This is shown by the history of the sheltering of Jews in the Second World War in the French town of Le Chambon-sur-Lignon, studied by Hauerwas and other commentators. What is most striking is the unheroic posture in which the community did its good work. This was based on the historical narrative of the town showing centuries of peaceful resistance to the Catholic authorities, a feature of a mountain community. In 1942 the police arrived to arrest the pastor, Andre le Trocmé, and while he was looking for a suitcase his wife offered the police some lunch. When asked by critics why she did this she said, 'It was dinner time . . . the food was ready. What do you mean by such foolish words as "forgiving" and "decent".'[66] It is just this matter of fact posture which is so striking, the sense that we offer hospitality to all visitors, including our enemies. It is noble in the sense of doing what needs to be done without striking a pose or thinking highly of ourselves. With this in mind we can say that supererogation is not so much 'above and beyond' duty, as characterised at the start of this chapter, but rather as *running alongside.* When we think of acts of supererogation after the event we see them as beyond our reach; we look up to such actors who have done great things in the eyes of the world. We remember Lord Nelson at the battle of Trafalgar, and his statue on top of the high column in Trafalgar Square demonstrates the vertical view in which we esteem him. But I am proposing that supererogation should also be seen in a horizontal dimension: the Battle of Trafalgar was won thanks to Nelson's tactical skill in forming a line of ships which took the French side-on. We can see him not soaring high above his men but leading them in his flag-ship, *pulling* his men to feats of courage and heroism which surprised even themselves, and he stood fully exposed

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[66] Samuel Wells, *Transforming Fate into Destiny The Theological Ethics of Stanley Hauerwas* (Carlisle: Paternoster Press, 1998), 137. The text continues: 'How can you call us "good"? We were doing what had to be done. Who else could help them? And what has all this to do with goodness? Things had to be done, that's all, and we happened to be there to do them. You must understand that it was the most natural thing in the world to help these people'.

to danger himself, being killed by a sniper's bullet from a French ship.[67] Supererogation in retrospect might seem a high and noble thing, worthy of plaques and statues on columns; but the actors in the drama are behaving in this horizontal fashion, pulling others behind them and showing them the way.

1.1.8. Frothy coffee

The difficulty in identifying the boundary between duty and supererogation is illustrated in a commonplace way by thinking of a cup of cappuccino. Everything depends on how we see such things. The froth is different from the liquid coffee yet is derived from it; the froth supervenes on the liquid, for without the liquid there could be no froth. Do we think of the froth as different from the coffee when both are in fact made of water and milk? To see them as different would accord with Heyd's view of supererogation sitting on a base of duty. But are they merely aspects of the same thing? The notion of so-called 'supererogatory duties' points to this blurring.[68] Changing the metaphor, we could say that supererogation stands on the shoulders of duty, for if we could imagine a doctor performing acts of supererogation whilst neglecting his ordinary duties, then we would not regard that as a virtue but rather a display of vanity or self-aggrandisement. 'Diva doctors' have recently been described in the media; they chase the limelight, undermine teamwork, and leave ordinary work to others.[69] Yet this model is unsatisfactory as a template because acts of supererogation can be performed without a foundation of duty to support them; the froth stands alone as it were in mid air. This can be seen in volunteers who perform unpaid jobs without any contract of employment. Yet it is not satisfactory to think of duty and supererogation as some sort of mixture or amalgam; from the outside looking on, duty is obligatory, while supererogation is not, and that difference must be

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[67] He had earlier refused to hide the military decorations on his coat so was easily identifiable by French snipers as he stood on deck of the Victory.

[68] Brenda Almond, 'Reasonable Partiality in Professional Relationships', *Ethical Theory and Moral Practice,* 8 (2005), 155-168. In discussing impartiality in professional life, and using medical examples, she finds that universal principles are impartial yet can still single out a specific beneficiary.

[69] A symptom of a 'toxic culture' at work: https://www.theguardian.com>society>aug>diva-doctors-rotten -culture [accessed 9 August 2022]. Narcissism might dress in the clothes of supererogation.

profound. If we think of supererogation as being above and beyond the call of duty then other images come to mind: the idea of irksome duty being left behind can be pictured as a flight into higher realms where we are motivated by the love of others. That too is problematic, for not all duty is irksome or unwillingly undertaken, and not all supererogation is done gracefully or with any sense of a noble calling; indeed people who exceed their duty and save lives commonly respond to grateful thanks with words such as, 'I was just doing my job'.

1.1.9. Doctors and the Beyond Duty Model

In light of the situations described above, I shall now try to list the imperfections of the Beyond Duty model from the medical point of view:

i) Firstly, a facile split of our duties at work into 'obligatory' or 'not obligatory', with the latter considerations being left to one side or simply discarded.

ii) Secondly, a reluctance to delve further into the topic as a whole.

iii) Thirdly, a low level of aspiration, or at least a reluctance by doctors to continually challenge themselves both as to what they do and *how* they do it.

There is a bovine acceptance that actions which are beyond duty are irretrievably beyond our doing, and that we should just get on with the fulfilment of our ordinary rounds. The problem for doctors who readily accept the Beyond Duty model is that it allows too simplistic a view of our duties: they can be ticked off one by one in a 'job done' manner. The challenge is to grasp, as Feinberg suggested, that 'a person's merit or worth [. . .] *all things considered*'[70] might well be calling for more, something beyond our grasp. That would leave doctors in a state of uncertainty, not knowing if they have ever done quite enough. This is the reason why doctors fight shy of the latter view and they become preoccupied by what is calling most loudly for their attention. This might be described as picking the low-lying fruit and not straining for the riper fruit just beyond our reach.[71] Whether we wish to live by just doing enough,

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70 Feinberg, 15.

71 Kirk describes how we may be seduced into attending to our ordinary sins and leave greater sins unacknowledged: 'If all sins are equal there can be no logical approach to their conquest. They may be taken in any order, and naturally enough the nearest and easiest is taken first, and preoccupies attention to the virtual exclusion of more important matter of duty'. Kirk, 521.

or by being more generous and perhaps self-sacrificial, is the perennial difficulty, and doctors need to know from which point of view they approach patients.

At the heart of the conceptual problem with supererogation, and especially with the Beyond Duty model, is the psychological splitting that occurs when we believe something is not just optional but beyond our doing: that leaves us free to disregard everything that is optional and indeed to take no notice of it. That is the worrying part, especially at work when we can become so dulled down by routine as to blind ourselves to what is clearly apparent. There is a comment attributed to Hauerwas which he learned from H. Richard Niebuhr: 'we must ask *What is going on?* before we can intelligibly engage the question, *What must we do?*'[72] I can assert that during forty years of medical practice the *What must I do?* was continually at the forefront of my mind; the *What is going on?* came second. *What must I do?* was foremost in order to keep patients safe, for the prevalent fear of doctors is failing in their duty of care, never mind thinking of going beyond duty. The Beyond Duty model seems to be the epitome of this blinkered view, and in further chapters I try to take off those blinkers and look around with wide eyes.

1.1.10. Conclusion to Part One

In this part I have outlined the Beyond Duty model and noted its strengths and weaknesses. The complexities might give rise to the idea that supererogation is a tenuous concept to grasp hold of, something which has in fact already been recognised by many authors, including Heyd, as described above. Nevertheless in this thesis, *pace* Heyd, I find that doctors can behave *as doctors* in a supererogatory way at work, and not just in the 'man-to-man' role he envisaged. Heyd seems to imply that the medical side of a doctor's character can be put to one side, as if it were simply a role to be performed at work or a 'skill set'. We can say this quite straightforwardly because if doctors do indeed have a list of duties, either formally given to them or resulting from a sense of 'that is all that the working day requires', then going beyond duty exists by definition: it is something which has to be admitted by virtue of the

[72] Michael G. Cartwright, 'Afterword: Stanley Hauerwas's Essays in Theological Ethics: A Reader's Guide' in *The Hauerwas Reader,* ed. by John Berkman and Michael Cartwright (Duke University Press: Durham and London, 2005), 634.

nature of the boundary. (The much more complex picture of a doctor not recognising a formal limit to duties will be looked at later in this thesis).

In conclusion to this section I believe that it is false to separate our actions as a doctor from our actions as a person; attempts to do so bring about incoherence within us. Yet it might be admitted that although a separation should not be made, nevertheless the two facets of our identity might overlap to some extent, with some doctors having a large overlap and others preferring to see themselves more bluntly as a doctor at work and not a doctor at home.[73] It would all depend on how a doctor comes to see this. I believe the recognition that we cannot separate ourselves into discrete aspects of personhood, reserving our 'good character' for home and just 'following orders' at work, should strengthen our resolve to work for patients in new and inventive ways, fusing our professional and personal ethics in an ever-present, virtuous manner.

What is of great interest is how we came to have such an unsophisticated view of duty, especially of a doctor's duty at work. It might be that the formulation of our professional duty itself cannot help but circumscribe our thinking into some sort of straightjacket. We need the virtues running all the way through us if we are to see clearly, to discern the fundamental aim of medical practice, that is the *telos* of medicine, so that we might benefit our patients as fully as we can. In the second part of this chapter I wish to think of the virtues, particularly as they were developed by Aquinas.

Part 2: The History of Supererogation: St Thomas Aquinas

1.2.1 Introduction

In the second part of this chapter I am looking at what we take for granted. The separation of what is required from what is optional is so deeply rooted that we need to look at the history of this belief. I have not found a published comprehensive

[73] Yet seamlessly blended by Dr James Pickles, GP in Wensleydale, whose close familiarity with everyone in the surrounding villages allowed him to study infectious diseases. His book, *Epidemiology in Country Practice* (1939) is a classic work.

history of the concept of supererogation, especially as it might apply in medical practice, but historical summaries have been made.[74] Aquinas provided an exposition for this belief by separating precepts from counsels in the Christian life. That is why I now describe his writings for they help to shine light on our taken-for-granted assumptions.

1.2.2 St Thomas Aquinas

Supererogation was identified by earlier Christian writers before Aquinas, including St Ambrose and St Augustine. Both distinguished between precepts and counsels, though their work was based on the Evangelical Counsels of poverty, chastity and obedience; these three were intended to overcome 'the lust of the flesh, and the lust of the eyes, and the pride of life' (I John, 2. 16). But we have to wait for Aquinas and the Scholastics for elaboration of the subject, and this is found in the *Summa Contra Gentiles* and the *Summa Theologica.* Central to this is the distinction between precepts and counsels, the former being the form of commandments required for justification leading to salvation, the latter being optional recommendations, attractive to those who are motivated by love of God and who desire to seek sanctification (Matthew 5.48).[75] Aquinas focussed on the cardinal virtues: temperance, fortitude (or courage). justice and prudence (ST, I - II, Q.61), seeing them as having a social function but also leading us 'even to Divine things' (ST, I-II, Q. 61, Art. 5). He then described the theological virtues in Question 62. Acts of supererogation are facilitated by the practice of the counsels, and such practice seeks for 'the perfection of human life'.[76]

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74 e.g., Heyd, chapter 1; Kirk, 517-523.

75 The contrast between precepts and counsels is illustrated in Anthony Trollope's novel, *The Warden*. The archdeacon 'is a moral man, believing the precepts which he teaches, and believing also that he acts up to them; though we cannot say that he would give his coat to the man who took his cloak, . . .' The Rev Septimus Harding, by contrast, takes such pains to see his opponent's point of view that he resigns the wardenship and consents for his daughter to marry John Bold who has caused all the trouble. The warden 'was not so anxious to prove himself right, as to be so.' Anthony Trollope, *The Warden* (Harmondsworth, Middlesex: Penguin Books,1986), pp. 14 and xxii.

76 Heyd, 20. *Summa Contra Gentiles,* Bk lll, Pt ll, ch.130.

Supererogatory acts are therefore seen as *opera meliora* for they are linked to perfection.[77] Supererogation is therefore a way of handling the open-ended nature of our obligations to each other. The Old Law is authoritarian and 'leaves no room for supererogatory ideals';[78] it is prescriptive in tone, too apt to lead to excessive self-referential interpretations,[79] whereas the New Law, including precepts and counsels, leaves latitude to choose the life we lead. As Aquinas states (ST I-II, Q 107, Art 1) 'The Old Law is said to restrain *the hand, not the mind,* . . . the New Law, which is the law of love, is said to *restrain the mind',* and indeed from the point of view of this thesis, our state of mind, including motivation and intention, are as worthy of attention as our acts. Furthermore 'the precepts of the New Law might appear more burdensome than those of the Old', but not if the person is virtuous:

> it is easy to do what a righteous man does; but that to do it in the same way, viz., with pleasure and promptitude, is difficult, to a man who is not righteous. (ST I-II, Q.107, Art.4)

The discretion we have in loving is shown by the fact that we can perform acts of supererogation intermittently, perhaps reverting to more self-regarding states of mind in between. Acts of charity, especially alms-giving, can be intermittent, idiosyncratic and chosen at random from the many calls upon us.[80] Aquinas' view of alms-giving is indicative of the difficulties of how to handle this virtue of charity. Heyd states 'that *generally* almsgiving is a precept',[81] yet much depends on the wealth of the giver and the need of the recipient, so it is hard to draw a boundary. Similarly, for beneficent acts Aquinas restricts the duty to perform them to certain circumstances, otherwise they become supererogatory. This indicates the fact that there is no clear boundary between duty and supererogation, at least as it applies to alms-giving, though difficulties are eased by love, as Aquinas finds in Augustine.[82] We could say therefore that love both makes duty easier to perform and it facilitates the transition

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77 'But if any man strike thee on the right cheek turn to him the other, *and thou shalt be perfect'.* The counsel advised by Didache. Kirk, 248.

78 Heyd, 22.

79 'A self-righteous complacency - a self-righteous scrupulosity - a self-centred despair - one or other of these is the inevitable result of a religion whose special emphasis is upon law'. Kirk,134.

80 I am thinking of alms which we cannot afford to bestow; ordinary alms-giving belongs within the realm of duty.

81 Heyd, 23.

82 'As Augustine says (*De Verb. Dom., Serm* .lxx), *love makes light and nothing of things that seem arduous and beyond our power.*' ST I II, Q.107, Art. 4, Reply 2.

from duty to supererogation. It might at first seem daunting to practise in a supererogatory fashion but the display of the virtues makes this easier: 'For my yoke is easy, and my burden light' (Matthew 12. 30).

One major consequence of this two-tiered approach of Aquinas was the belief that those who chose the monastic life were superior to those who followed the secular life, and this found expression in a variety of modes of self-denial which shaded off into self-mortification. Spiritual hunger could only be satisfied by depriving the body of all comfortable things, not just food and clothing, warmth and conversation. We nowadays gawp at the excesses of asceticism which were zealously pursued, for example St Jerome praised 'apathy towards a death in the family', and he also praised a lady who showed great equanimity when she lost her husband and two sons in quick succession.[83] The notion of one form of Christian life being superior to the other was described by Kirk as saving Christianity, for it permitted the church to embrace within its folds both the extremist who favoured self-denial and the worldly Christian who was content to make a living and enjoy some measure of material comfort and success. The price paid for this accommodation was the creation of a double standard (which Kirk calls the valid theory and the invalid theory) with opportunities for one group to look down on the other. The invalid theory claimed that the monastic life was inherently superior to the worldly life, whereas the valid theory showed that the two forms were different in degree but were not in separate categories.[84]

Kirk describes how complex and prolonged was the battle over these rival theories, with positions intensely held; he showed how the invalid theory seemed to have more prestige,[85] yet took pains to praise the valid theory as more truly Christian. We cannot separate ourselves into spiritual and corporal beings, any attempt to do so is false.[86] The valid theory, which emphasised the parity of the two ways of life in the eyes of God, put the active life as a stage on the way to the contemplative life: the

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83 'Would you not suppose that in her frenzy she would have unbound her hair, and rent her clothes, and torn her breast? Yet not a tear fell from her eyes'. Kirk, 178. Kirk might have had such attitudes in mind when he referred to the 'psychological menace' of the Apostolic Fathers. Kirk, 134.

84 Kirk, 242-257.

85 'The great error of the invalid theory [. . .] was the suggestion that anyone who for whatever reason refused this "generally higher" way of life was *ipso facto* debarred from the highest rewards or attainments of Christianity'. Kirk, 520.

86 'Live like men, that is, like embodied souls; and remember that souls embodied cannot behave as though they were disembodied'. Attributed to Aquinas by Kirk, 384.

vision of God was open to all, not just to those who were self-sacrificial. Further, 'the race is a long one',[87] and perfection, if it is to be achieved, is to be won by gradual change. For our purposes the importance of the latter idea is that, 'The immediate duties (e.g., the "active life") rank as "precepts" to be obeyed at once; the ulterior aims may be held in reserve as "counsels" for the present, which will become, we may hope, precepts or immediate duties by-and-by.'[88]

Aquinas shows that the contemplative life and the active life are in a dynamic relationship with each other. He describes how we might be called away from the contemplative life in order to satisfy the demands of charity, yet all the while not being forgetful of the 'contemplation of truth'. It is by such contemplation that we can avoid being overwhelmed by the burden of the active life in the world. This points to a rich and complex relationship between the two forms of life, and being called to the active life from the contemplative life is not to be seen as a subtraction but as an addition (ST2, Q 182, Art 1, Reply to Objection 3).

An important point of difference between the scholastic and modern views of supererogation is also brought to light in the *Summa Theologica*. We now tend to think of supererogatory acts as being the work of an individual agent whose actions might be described as heroic, but for Aquinas supererogation was based on communal activity and was not to be centred on an individualistic approach. He wrote in favour of supererogatory acts only in relation to a community, and when such acts were both good for the agent and good for the recipient.[89] Aquinas was interested in the flourishing of a community as a whole, of which an individual was just a small part. An act of supererogation could be thought of as the gift of the Holy Spirit from which the community benefited.

It would be difficult to find a place for this model of supererogation, based on Aquinas, in modern health services. It would require a foundation of strong communal activity and shared work, and the modern tendency towards egocentric views counts against such focus on community work. We can perhaps see just how

87 Kirk, 243.
88 Kirk, 243.
89 James Dominic Rooney, 'Vocation to Love: Supererogation in Aquinas', *International Journal of Systematic Theology,* 24(2) (2022) 156-172.

damaging the absence of such views proves to be in hospitals where the work culture is dysfunctional.[90]

The development of the mediaeval church can thus be seen as an intertwining of *i)* precepts and counsels; *ii)* the monastic and the secular; *iii)* adequate service and meritorious service; *iv)* the active and the contemplative. Kirk gives an example of how almsgiving became a substitute for virtue;[91] it became acceptable to imagine ourselves as so meritorious that we might not simply shine in the face of God but see God as being in debt to us, something Kirk believed was bound to lead to disaster.[92] That disaster became 'cashed out' in terms of the treasury of merit, the spiritual bank account kept in heaven; deposits were credited to the treasury by the works of saints, and drawings made to atone for the sinful. It was bound to lead to corruption, and perhaps worse, a sense of the mechanization of faith; whereby atonement could be obtained by making sufficient payment; and that led to codes of behaviour and practice where the outward behaviour was observed and the state of mind left out of the equation.[93] Legalism and formalism go hand in hand, and the deadening effects of such attitudes can be seen in the ship's surgeon to be described in the next chapter.[94] The sin seems to be one of lack of imagination in the service of others, a deadening attitude which leads to anomie.[95] Legalism leads us to look further at the underpinning of Aquinas's work, and we find this in natural law.

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90 Aquinas' point of view is illustrated in a negative way by recent hospital scandals. When things are going badly doctors tend to work in increasingly 'defensive' ways, and can lead 'atomic' professional lives, far removed from the flourishing communal spirit one wishes to find in hospitals. Works of supererogation seem rare in such institutions where even well-intentioned and dutiful 'whistle-blowers' can suffer adverse effects..

91 'Thou hast alms; ransom thy sins. God cannot be bought, but thou canst be bought off; buy thyself off with money'. Attributed to Ambrose. Kirk, 139.

92 'If we do well, we merit of God, and He becomes our debtor'. Attributed to Tertullian. Kirk,139.

93 In Chaucer's *The Pardoner's Tale,* part of *The Canterbury Tales,* we are given a flavour of the corrupting sale of pardons, but expressed in a humorous and crude style.

94 'That legally expressed codes tend to place preponderant emphasis upon correct behaviour, to the relative disregard of purity of motive, and to substitute punctiliousness for piety, is the central kernel of our Lord's teaching about the law.' Kirk, 132.

' [- - -] "formalism" stands for a type of code not so much heroically ascetic, as detailed and meticulous - a code which delights to prescribe duties, not necessarily of an arduous kind, for every conjuncture of life, and to leave little, if anything, to the autonomy of the individual conscience'. Kirk, 9.

95 'Congenial, or at all events simple, duties will provide a substitute for irksome and complex ones; a surplus of simple duties correctly performed will avail in the rainy day even for premeditated derelictions. This is the theory of the relief of sins by alms [. . .] and it stands on the threshold of the doctrine of merit and works of supererogation'. Kirk,138.

1.2.3 Natural Law

We cannot grasp the theology of Aquinas without an understanding of natural law. The Summa Theologica is posited upon the love of God at the heart of human life, and so has a basic orientation to the good: indeed, we find salvation by following the good (ST I-II, Q. 94). So natural law is not simple or 'natural' in the modern sense, meaning unsophisticated or attained without effort; the Summa Theologica itself is a demonstration of the importance of the exercise of right reason in light of the virtues. The pursuit of the good requires us to seek rational ends in a virtuous way. Yet the end or *telos* is expressed simply: it is human flourishing. Our norms of behaviour are not arbitrary or easy but are 'about structures of living that promote human flourishing'.[96] We are to keep that constantly in view. That commitment to the good is foundational and inescapable, and cannot be neutralised by wrongdoing. As Stephen J. Pope states, 'Our basic orientation to the good is not extinguished by wrongdoing; even liars resent being lied to, and those who steal get morally outraged when stolen from'.[97] Furthermore we discover natural law for ourselves, and that takes place 'within the narrative context of experiences that engage a person's intellect and will in the making of concrete choices'.[98] It should be said that natural law has nothing childish about it; it can only be grasped by those who are mature and wise; it is self-evident but not innate.

It is in this context that the narrative disclosure of literature, as I intend to show in later chapters, can be especially beneficial in developing our understanding of this process. It is in literature that one can see characters develop in maturity; here, as with Aquinas, we see the process of self-evident principles being finally grasped from lived experience without the intervention of inference of any sort.[99] I encourage

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Anomie is 'the breakdown of the conventions of everyday life, weakening of a society's collective self-image or social laws'. *The Oxford Companion to Philosophy,* ed. by Ted Honderich (Oxford: Oxford University Press, 2005), 38.

96 Stephen Pope, 'Reason and Natural Law' in Gilbert Meilaender and William Werpehowski, *The Oxford Handbook of Theological Ethics* (Oxford: Oxford University Press, 2007), 163.

97 Pope, 163. Also Milton in *Paradise Lost* (1667) bk. 4, 1, 108: 'So farewell hope, and with hope farewell fear. Farewell remorse! All good to me is lost; Evil, be thou my good'.

98 Pamela Hall, *Narrative and the Natural Law* (Notre Dame: University of Notre Dame Press, 1994), 37; included in Pope,163.

99 Finnis, 33-34.

doctors to read literature, and for those doctors interested in understanding the history of natural law in English Literature then the study of the works of Shakespeare gives great insight, especially in the tragedies.[100] We see characters being driven to good and bad ends; thus good characters accept obligation as contributing to the human good, and they integrate their own wishes with their obligations; that is how they flourish. The bad characters live in a state of tension whereby their obligations grate continually against their inclinations, and they soon begin to show resentment, devoting much craft and energy to shirking their obligations. They shrink as a result. From the point of view of bioethics, natural law has made a modern reappearance as an alternative point of view from which to discuss vital issues such as abortion, euthanasia and indeed basic human rights.[101] The influence of Aquinas thus still continues. I now wish to look at the relationship of natural law and the virtues in the light of Aquinas.

1.2.4 Christian Prudence

Let us look at the virtue of prudence more closely as it is a good example of how our interpretation differs from the mediaeval mind. Aquinas includes it with the other cardinal virtues of justice, temperance and fortitude, but prudence governs and shapes them.[102] What then is the relationship of prudence to supererogation? We can distinguish between natural and Christian prudence. To the modern mind prudence is concerned with carefulness, rather a lacklustre virtue, short of vigour and boldness. In the words of Adam Smith, it merely 'commands a certain cold esteem'.[103] This compares with Christian prudence which is in the service of charity. Prudence is an intellectual virtue concerned with how to make manifest our goodness in the world. Natural prudence might seem opposed to the riskiness of supererogatory behaviour,

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100 R. S, White, *Natural Law in English Renaissance Literature* (Cambridge: Cambridge University Press, 1996).

101 Alfonso Gomez Lobo and John Keown, *Bioethics and the Human Goods: An Introduction to Natural Law Bioethics* (Washington: Georgetown University Press, 2015).

102 Prudence is the *auriga virtutum*, or 'charioteer' of the four cardinal virtues (Aquinas). In this it might be likened to the pituitary gland at the base of the brain which has been described as 'the leader of the endocrine orchestra', governing the secretions of the other endocrine glands.

103 'Prudence, in short, when directed merely to the care of the health, of the fortune, and of the rank and reputation of the individual, though it is regarded as a most respectable, and even, in some degree, as an amiable and agreeable quality, yet it never is considered as one, either of the most endearing, or of the most ennobling of the virtues. It commands a certain cold esteem, but seems not entitled to any very ardent love or admiration'. Smith, *TMS,* 253.

yet Christian prudence might embrace supererogation if such a path promised to promote salvation, all achieved in a rational and well considered manner. The application of prudence is concerned with discerning wisely according to right reason and in the light of God: 'thus prudence sees nought else but the things of God' (ST. I II, Q.61, Art.5).

We can see that prudence in its modern guise lingers on the boundary between duty and failure of duty; it satisfies itself with being 'good enough', and its greatest fear is to fail in duty. Doctors who practise 'defensive medicine' are preoccupied with this state of mind; it achieves the minimum, avoids danger, yet leaves much undone which might have been done by working in a more robust state of mind. Those defensive medical practitioners tend to 'scrape along the bottom', understandable perhaps in view of the dangers to patients caused by failures of duty and the fear that engenders, yet unsatisfactory nevertheless. A doctor who has knowledge and skill to hand but who is also imaginative can be said to have attained Christian prudence. On the one hand Aquinas states, 'For the virtue of prudence resides in this: that the objective cognition of reality shall determine action; that the truth of real things shall become determinative'.[104] That reality is a Christian one. On the other hand Josef Pieper states, 'Christian prudence, however, means precisely the throwing open of this realm and (in faith informed by love) the inclusion of new and invisible realities within the determinants of our decisions'.[105]

Doctors who work with Christian prudence might be said to dwell, by contrast with defensive doctors, on the boundary between duty and supererogation; they do not practise defensively but leave themselves vulnerable to others, relying on a good command of medical knowledge and skill to protect themselves and keep their patients safe. Most importantly, they perceive the 'new and invisible realities' open before them, and these need not be miraculous in nature, simply the results of attentive watching and 'being with' patients.[106] This is the Christian imagination put

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104 Josef Pieper, *The Four Cardinal Virtues* (Notre Dame: University of Notre Dame Press,1966), 15.

105 Pieper, 37.

106 Chemotherapy for lymphoma and leukaemia had its origins in doctors noticing the lowered white cell counts in victims of mustard gas poisoning during the First World War.

to work, a creative process founded on love, but tempered by rationality and justice and wholly committed to the good.

1.3 Conclusion

In this first chapter I have described the Beyond Duty model. It is an attractive model at first reading, for it provides a formula for deciding where the boundary lies between duty and supererogation: as soon as we delve deeper into examples we see that the complexities of life are rarely settled in such a binary way. It found expression in the work of Aquinas with the division between precepts and counsels, something which sounds easy in the abstract but which is difficult in practice. The giving of alms and acts of beneficence show this tension. The distinction between precepts and counsels is worthwhile, for it is a humane attempt to make the path to salvation more bearable for people whose lives are very difficult; yet an exclusive focus on the precepts leaves out much that might be required. Some patients need more than the simple treatment of their disease, and for such patients doctors need to extend themselves beyond their duties.

In later chapters I shall outline two further models of supererogation which I believe will give a fuller and more satisfactory account. In particular I am concerned that over-focus on what we judge to be reasonable might exclude what is important, and although we now tend to be dismissive of the excesses of asceticism shown by the Fathers of the Church, perhaps they have something important to tell us: supererogation is, after all, *unreasonable* in its demands upon us.[107] In the next chapter I look at our obligations one to another, and then look at the work of recent philosophers to see how much further light we can throw on this topic.

[107] Toulmin comments on what is reasonable: 'The truth is that, if different people are to agree in their ethical judgements, it is not enough for them all to be fully informed. They must all be *reasonable*, too.' Good reasons cannot persuade those who are 'wholly unreasonable'. Toulmin, 165.

2. Chapter Two: Our Obligations One to Another

2.1. Introduction

In the first chapter I described the prevalent model of supererogation as based on a sense of 'duty-plus', and I then described its weaknesses, primarily its too restrictive view of supererogation emerging from a base of duty. To deepen our understanding we now ask the question, What are our basic obligations to each other and how do they interact with our professional duties as doctors? In order to clarify the distinction I use the device of an imaginary, modern-day doctor, *Dr* Robinson Crusoe, and describe his duties to an injured man on a desert island; this device has been chosen because I am here trying to discern our moral obligations *ab initio.*

In the second half of this chapter, in order to illustrate the nature of our professional responsibilities, I imagine a doctor involved with the care of patients during a hospital strike, and I examine his responses. I argue that in cases where we find ourselves 'just doing the right thing' according to the circumstances in which we find ourselves, then supererogation is likely to become ill-defined. Nevertheless I propose that the concept of supererogation should be retained in medicine, and I formulate a separation between moral obligation and professional duty; this formulation will make it easier to understand what has gone wrong with biomedicine and what might help to put things right.

Finally I look at the work of two modern philosophers, Bernard Williams and Alasdair MacIntyre, who have written extensively on moral obligation, and I examine how deeply our professional duties should pervade our lives. Williams in particular is keen to free us from the tyranny of moral obligations, and MacIntyre looks closely at how duty and virtues become integrated.

I am claiming that any separation between moral obligation and professional duty leads to unfortunate, if not dangerous, consequences, and I am anxious to fuse them together. I see supererogation as a device to further this end and so I begin with a look at the nature of moral obligation.

2.1.1 Part One: Duties and Obligations

In the first part of this chapter I examine our duties and obligations. I first look at our moral obligations, then at how these interact with professional duties, and finally I suggest how these two aspects have become out of balance.

2.1.2 What do we owe one another ab initio?

Let us imagine a modern doctor who was struggling to understand the nature of duty and how that related to his obligations outside work. What he owed his patients as a doctor was easy to state: restoring them to health, treating their disease, curing them where possible, and certainly caring for them as best he could. He could not though make out how his person-to-person obligations might be easily separated from his duties as doctor-to-patient; he could not quite distinguish *ab initio* requirements from the evolved practices of medicine in which he worked. That boundary seemed very blurred. With this in mind he found himself conducting a thought experiment, trying to separate his moral obligations from his professional duties, and his imagination ran along the following lines.

2.1.3 *Dr* Robinson Crusoe

One of the best known literary sources we have of two people being confined within the world of universal human obligation, with no sense of professional duties pressing upon them, is the world of Daniel Defoe's *Robinson Crusoe*, first published in 1719.[108] It is based on a true story of a sailor, Alexander Selkirk, choosing to live alone on a remote island after a quarrel with the captain of the ship he was sailing in. In the novel Crusoe saves the life of Friday, a member of a cannibal tribe who was about to be sacrificed, and then the two are left alone on the island to survive as best they can. They have moral obligations to each other, e.g., Crusoe's rescue of Friday from the cannibals; however they cannot quite start again with *ab initio* requirements, for their presuppositions are immediately apparent: Crusoe sees Friday as 'my man',

[108] Daniel Defoe, *Robinson Crusoe* (London: Penguin Classics, 2001).

his servant, and Friday prostrates himself before his rescuer. Yet things soon change: in their mutual service they both like and grow to love each other.[109] When they talk of the possibility of Friday's return 'to his own country' Crusoe becomes jealous and feels that Friday will 'forget all his obligation to me'.[110] Here we see person to person interaction coming to the fore over the putative master and servant relationship. Yet when rescue finally comes Crusoe reverts back to his societal role of a European in charge of his servant, and Friday rather drops out of the picture. We can see those few years of their time alone as illustrative of person to person obligations, unadulterated by the social intrusion of others, but the gap between them opened up again when rescue reminded them of their differing origins.

Again, what do they owe each other *ab initio*? Clearly not to harm each other, and perhaps this would only arise in circumstances of suspicion or hostility in the context of scarce resources. Also to do good, and the beneficence we show to one another comes to the fore when we are not threatened; Crusoe's saving of Friday illustrates the basic desire to help others, especially when we see injustice taking place.

To add verisimilitude to our experiment, and to remove confounding variables, let us imagine a present-day *Dr* Crusoe, the only survivor from a stricken ship. He has been washed up on an island, and is surprised and pleased to meet the present-day *Mr* Friday, by chance a survivor from an earlier shipwreck (this device to remove any paternalism of the doctor towards an indigenous inhabitant). Furthermore, no medical equipment or medications have been washed ashore, so the doctor stands before the other survivor stripped of all the accoutrements of his profession.

We could imagine, in our own scenario, Mr Friday being suddenly swept back out to sea by an enormous wave. Would Dr Crusoe have dived in to try and save him? I think we could easily see him risking his life to do so, just as any person might, irrespective of medical training. Why should this be so? Again, I do not think inference is involved. We do not think, 'His life is worth saving', or, 'I would be

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[109] 'besides the pleasure of talking to him, I had a singular satisfaction in the fellow himself; his simple unfeign'd honesty appear'd to me more and more every day, and I began really to love the creature; and on his side, I believe he lov'd me more than it was possible for him ever to love any thing before'. Defoe, 168.

[110] Defoe, 176.

completely alone without him'; rather we plunge into life, without calculation. This accounts for some of the tension in appraising supererogatory actions; they seem to display intelligence operating in a different way; inference gains no purchase.

Let us imagine Mr Friday has been injured and Dr Crusoe has to do what he can. He might wash the wound and dress it, perhaps using leaves bound with twine. He would want to find food, offer it to his patient, and boil fresh water if this could be found. (Defoe permitted *his* Crusoe to swim to the wrecked ship and bring back some provisions in barrels: no such amelioration on *this* island). The situation would be desperate. Could anything more be done? We are suddenly plunged into the world of universal moral obligations devoid of the doctor's professional resources. The doctor might offer some hope of cure if the wounds did not look too serious, and he could comfort and distract the patient from his suffering when analgesics were not to hand. At worst he could simply stay with the patient, day and night, not abandoning him, being ready to bear witness to his suffering, sitting on the ground in silence and sharing his grief like Job's friends, Eliphaz, Bildad, and Zophar.[111]

This impotence is important, acknowledging that suffering cannot always be relieved, but that bearing witness is an *ab initio*, fundamental obligation; refusal to bear witness or not to acknowledge suffering leads to the sufferer being demoted to the category of non-persons.[112] That is a side-effect of doctors rushing from one job to another, of being preoccupied with what can be done; the emphasis on cure obscures the standing need to care. This is a serious failure of medicine, especially when doctors neglect patients near the end. In fact stasis is a part of good medicine.[113] The important point here is that just because the doctor's biomedical skills have been rendered impotent, it does not follow that Dr Robinson is treating Mr Friday just as any non-medical person might do: his medical habitus remains; the man cannot be divorced from his role. The central message of this paragraph is however that universal moral obligations always

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[111] Job 2. 11-13. Job said that his grief and calamity if 'laid in the balances together . . . would be heavier than the sand in the sea', (6. 2-3).

[112] Perhaps the first step on the road towards treating someone as *Homo sacer.* The best preventive medicine for this is to talk to patients, even when they are unconscious, as shown by nurses when washing patients on intensive care units.

Stanley Hauerwas describes our fear of dying alone in 'Practising Patience: How Christians Should Be Sick, with Charles Pinches (1997)' in *The Hauerwas Reader,* ed. by John Berkman and Michael Cartwright (Durham and London: Duke University Press, 2001), 353.

[113] 'We should rush to do nothing' is an old medical aphorism.

remain, whatever circumstances we find ourselves in, and for doctors especially when professional skills have been rendered impotent. In short, it might be difficult to disentangle our fundamental obligations from professional duties, but obligations come first: professional duties supervene upon moral obligation, not the other way round. I intend to highlight this further in the next section.

2.1.4. The Cruise Ship Arrives

Let us imagine a second scenario in which Dr Crusoe dies of a tropical infection soon after the shipwreck, just as a modern cruise liner approaches the island and a party comes ashore. Mr Friday is found alive, but very ill; he is taken on board and attended by the ship's surgeon, an efficient doctor with modern medical equipment. Mr Friday is unable to communicate with anyone as no one speaks his language, yet he is looked after: his wound is dressed; he is examined carefully; medication is prescribed; he is fed and given clothes. At the next port a translator will be found to help further. He has nothing to complain of except the lack of communication of the surgeon who just does what needs to be done in a competent but distant manner.

It turns out that the surgeon left civilian practice because he could not relate to patients. He preferred to get on with the job, saying to himself that the sooner he could make them better the sooner they would stop bothering him. His colleagues acknowledged that he knew his medicine but had a hopeless bedside manner; they 'let him go' and began the search for a replacement partner with much better interpersonal skills. Irritable and impatient by nature, he could however act the part, knowing just what to do to avoid complaints. He had little feeling for the patients on board ship, but kept up-to-date, disregarding patients' state of mind and concentrating on their symptoms. His faults did not come to light as his contacts with the passengers on board were short and focussed on the presenting problem. Although technically competent, he was lacking in virtue.

Mr Friday is taken ashore at the next port, a translator is found, and contact is made with his family. Now he is looked after by a third doctor. This doctor is affable, genial, fascinated by adventure and eager to talk over a glass of whisky. Not much

interested in medical science, he has let himself get badly out-of-date and indeed prefers to talk and socialise. He looks red in the face, and indeed his 'heart has waxed gross'.[114] Popular with patients, especially when they are not very ill, he tries to please with prescriptions for what they desire, and prefers to let nature get on with the job. He is busy being himself and only pays attention to patients in an instrumental way. As a consequence of this neglect he fails to notice the anaemia that Mr Friday now suffers from as a result of his injury.

2.1.5. 'Which now of these three, thinkest thou . . . ?[115]

Such imaginary scenarios always sound far-fetched, yet the second and third doctors have their prototypes in doctors whom I came across in a long medical career. They stand for the two common faults of doctors: firstly, being too interested in the science of medicine at the expense of the human touch; secondly, being too interested in personality and adventure at the expense of science and technology.

While we might think the ship's doctor was the most effective for Mr Friday, at least from the bio-medical point of view, yet I find that the best of the three doctors is in fact the first one, the modern-day Dr Crusoe, and I claim this despite his biomedical impotence. He shows fundamental care and concern for Mr Friday, being directly involved with him, moved by his need, and distressed by not being able to do more. The second and third doctors show an unpleasant detachment. This is obvious with the ship's doctor who attends to injuries without attending to the patient; notwithstanding his competence he is lacking the grace of good manners, and at times showing a hardness of heart. He might be so lacking that he cannot even recognise 'basic moral notions'.[116] The detachment is not so obvious in the garrulous doctor in port, yet his own comfort and interests intrude between himself and his patient. In both we see the technique of distancing, of being semi-detached, something which goes beyond an appropriate manner into a self-absorption which is hurtful and liable

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114 Matthew 13. 15. Drinking too much alcohol is one of the causes of degeneration of the heart muscle.

115 Luke 10. 36.

116 '[. . .] some degree of empathy for others is a necessary condition for understanding the basic moral notions'. Jean Porter, *Moral Action and Christian Ethics* (Cambridge: Cambridge University Press, 1995), 183. At the far end of this spectrum are found psychopathic people.

to do harm. In the ship's surgeon there is over-medicalisation, or at least too much of the medical gaze; in the genial doctor there is self-gratification. What we owe each other *ab initio* is fundamental care, expressed as charity, which is direct and not modulated by anything interposed between us, and Dr Crusoe exemplifies this. Fundamental care can be overlaid by other qualities, such as the attentive busyness of getting on with the job, but its lack cannot be made good by becoming ever more efficient or preoccupied with other qualities.[117] We could say therefore that our moral obligations come first, and our professional obligations second; these are grafted onto us during medical education. The medical profession has built a huge superstructure out of those professional duties, something which dominates the bio-medical landscape, at least from doctors' point of view. The danger is that we discount our moral obligations as something which can be left to look after themselves.

In this imaginary scenario I have shown how our fundamental obligations can be overlaid, indeed lost sight of, by acquired habits of the professional settings in which we work. In the next section I explore how we can reconnect with these obligations.

2.1.6. Care and cure

We care for patients, but if we are to show charity to each other, then this care would have a different flavour. Modern care focuses on bodily concerns, on body-mass index for example, or nutrition and exercise, and such like. Charity has an old-fashioned timbre; it is linked to giving at cost to oneself, having honourable biblical roots, though tainted for some by the nineteenth century paternalism of the workhouse. Charity concerns itself with the whole person.

Paul Ramsey, in *Basic Christian Ethics,* dwells on the notion of what we need to do to reach a state of charity towards others.[118] It is not simply giving one's goods or even of oneself; it is concerned with giving in the right manner, in a state of maturity, and

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[117] The author remembers one registrar, who singled out patients with a palpable liver for use on teaching rounds, showing a disregard of them once the round had finished. Although essential for students to learn how to palpate a diseased liver, the satisfaction of provoking diagnostic signs should not blind us to the discomfort of the patient after a whole medical team has taken turns to feel the offending organ (a supererogatory submission by the patient).

[118] Paul Ramsey, *Basic Christian Ethics* (London: John Knox Press, 1993).

here attitude is vital. Charity is now seen as a state of mutual benefaction. Ramsey makes several illustrations of the point. He refers to St Paul's conception of Christian maturity with a quotation from 1 Corinthians, 14. 20,[119] and from Ephesians comes a plea for what could be read as holistic charity:

> But speaking the truth in love, may grow up into him in all things, which is the head, *even* Christ: From whom the whole body fitly joined together and compacted by that which every joint supplieth, according to the effectual working in the measure of every part, maketh increase of the body unto the edifying of itself in love. (Ephesians 4. 15-16)

That sounds like a call for a maturity, giving of ourselves wholly, wisely, and generously; it also stands for a wholeness of society with no one being excluded from the body of persons. Ramsey goes on to say, emphasising the need for maturity, that,

> the standard for perfect maturity is not drawn from a consideration of human capacities in general . . Beyond any doubt, the standard for man is not drawn *from man*; what is expected *of us* is not taken *from us*. Here Paul plainly links maturity with the measure of the stature of the fullness of Christ.[120]

The shipwreck drama is offered as a parable comparable to the Good Samaritan. We might now ask, in that spirit, 'Which now of these three, thinkest thou, was neighbour unto him that was shipwrecked? [121] The maturity of Dr Crusoe is, I hope, better appreciated in this light: his not knowing what to do for lack of medical equipment, his failure of experience faced with plants he cannot use; these are set aside by his charity towards Mr Friday. He does what he can, however futile, and this is a sign of his love. This is love as *agape,* the love of charity based on love of God, and which extends to our love for people other than family and friends. His concern with Mr Friday shows 'edification' in Ramsey's words. The paralysis of his biomedical functions leaves him free to meet his ordinary obligations without hindrance, and the edification to be found, I suggest, is that we do not need a list of duties to be told how

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[119] 'Brethren, be not children in understanding: howbeit in malice be ye children, but in understanding be men'. Parson Adams in Henry Fielding's novel, *Joseph Andrews,* is a child in malice, yet he is no fool. He knows he is sometimes taken advantage of yet still prefers to be open-hearted rather than distrust the stranger.

[120] Ramsey, 196.

[121] Paraphrasing Luke 11. 36.

to behave to our neighbours: indeed that is the bedrock of our obligations. We might say that he behaves well to his neighbour, showing the fulfilment of his caring obligations as *infused* by his medical experience. Good doctors attend to the pain a patient might be feeling, not just bodily pain but anxiety too: *ataraxia* can still be sought for the patient in the absence of medical equipment.[122] So care continues even when opportunities for cure have been lost.

The failure of the other two doctors is shown by their preoccupation with self. Theirs is a failure of generosity, they withdraw into the worlds they have circumscribed for themselves. Their parts do not form a whole, they remain out of joint in themselves and cannot join to others. The attitude of the genial doctor on shore is more dangerous for the patient, for much might be missed; the ship's surgeon, though not dangerous, seems more pernicious in attitude, indifferent as he is to the person of the patient. Both have erected defensive walls; there they remain. Dr Crusoe, by contrast, is in the world of others in a professional and personal manner, leaving himself vulnerable because he has not constructed psychological defences against others.

2.1.7. Detachment and Uncoupling

The ship's surgeon ignored his fundamental obligation, here not much more than an ordinary kindliness, in the person-to-person mode; the doctor on shore neglected his professional duties. These two modes need to be melded together in a pleasing whole, not broken down into parts, and when the technical medical function is paralysed, as happens on the desert island, then the fundamental obligations can still shine forth unhindered. We should be aware of such fractures within us; they occur when we are outside our usual working practices and under great stress. We can mend them by reflecting on our behaviour in the light of patients' responses; the examples of fine medical practice witnessed on ward rounds, and discussions with colleagues also contribute to this.

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[122] *Ataraxia*, the freedom from anxiety, is an ancient approach to suffering; along with freedom from pain it constitutes *eudaimonia* in the philosophy of Epicurus. In Christianity the saying of Julian of Norwich, 'And all shall be well. And all shall be well, and all manner of things shall be well' captures the peace that can be found even as death approaches.

On the desert island we could say that life is lived in a raw state, with primitive responses, good and bad, unimpeded by societal restraint. The complete stripping away of ordinary responses is seen in the vulnerable status of *homo sacer*, a concept from the ancient world, described by Giorgio Agamben who found it applied to the treatment of 'life unworthy of life' in the Nazi concentration camps.[123] Such a mixture of good and bad, altruism and fatalistic indifference, is shown by Daniel Defoe in a second work, *A Journal of the Plague Year* (1722).[124] Normally we go about our lives showing the 'civil inattention' described by Erving Goffman,[125] for example being pressed up close on trains and buses yet barely expressing our awareness of each other. A modern variant of this has been highlighted by Dr Kate Granger who, whilst a patient herself receiving chemotherapy, became upset and disturbed when staff did not take care to introduce themselves on entering her room.[126] Some doctors are dangerously adept at switching into such uncoupled states. This whole thesis is a plea for doctors not to permit themselves to become detached from their humanity.

What has gone wrong with the ship's surgeon and the doctor on shore, bearing in mind that they were competent enough to pass medical exams and that they remain on the medical register? Their failings illustrate a psychological departure from the former self, and indeed from the future self, as described by Nagel: such doctors display a sort of broken-up persona, lacking a sense of coherent continuity over time. This seems commonsense, but Nagel points out the philosophical difficulties here.[127] As well as the fragmentation such doctors display, which Aquinas might have diagnosed as *acedia,*[128] they appear to have, at bottom, an impaired sense of the

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123 Giorgio Agamben, *Homo Sacer: Sovereign Power and Bare Life,* trans by Daniel Heller-Roazen (Stanford, California: Stanford University Press, 1998).

124 The *Journal* is fictional, but masquerades as a piece of factual journalism. The mixed motives of the doctors, both licensed and 'quacks', are well brought out by Defoe.

125 Erving Goffman, *Relations in Pubic* (London: Penguin, 1972), 385.

126 Dr Kate Granger https://hellomynameis.org.uk/ [accessed 1 Augsut 2022]

127 'The idea of a temporally persistent human being is an exceedingly complicated one, and many philosophical problems can be raised about it . . .' Thomas Nagel, *The Possibility of Altruism* (Oxford: Clarendon Press, 1970), 60.

128 *'Acedia* is the dreary sadness of a heart unwilling to accept the greatness to which man is called by God; this inertia raises its paralyzing face wherever man is trying to shake off the obligatory nobility of being that belongs to his essential dignity as a person, and particularly the nobility of the sonship of God, thus denying his true self'. Pieper, 200.

particularity and wholeness of themselves and their patients.[129] They have so-called 'facades' and blind spots, those areas of the Johari window which are not known to ourselves but which are sometimes discerned by others.[130] A pathologist, for example, might have been led into the speciality because of a fascination with morbid anatomy, yet he might have unwittingly followed this path because of a lack of ease with patients. Self-knowledge might be obtained by making small revelations of ourselves to others who might then in turn comment on our behaviour. This can bring to light unwelcome things which we then have the opportunity to change, if courage can be found. Another route to self-knowledge, at least for those sensitive to such insights, might be to study a poem such as the bitterly ironic, *The Naming of Parts,* in which soldiers training in the Second World War are lulled into the eventual use of a gun by dismantling it and then describing each part in a desultory manner.[131] The gun is thus uncoupled from its lethal function, just as the two doctors I criticize are disconnected from the patient's suffering.

There is a sense of splitting at the heart of this; doctors need to see the generality in all patients, and the particularity in each, uniting the universal application of biomedicine with a perception of the suffering individuals before us.

Patients require doctors to be competent and to be mature enough to face suffering, and to bear some of the pain of others. This might sound facile, that we might bear the pain of others, for as Hauerwas states,

> The difficulties pain creates in terms of our relations with ourselves is compounded by the peculiar difficulties it creates for those close to us who do not share our pain. For no matter how sympathetic they may be, no matter how much they may try to be with and comfort us, we know they do not want to experience our pain. No matter how

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129 'To recognise others fully as persons requires a conception of oneself as identical with a particular, impersonally specifiable inhabitant of the world, among others of a similar nature'. Nagel, 100.

130 Johari window A technique devised by the psychologists Luft and Ingham in 1955 for revealing the areas of self-knowledge and self-blindness.

131 Henry Reed, *Naming of Parts*, part one of *Lessons of War*, The New Oxford Book of English Verse 1250-1950 (Oxford: Clarendon Press, 1972). 'To-day we have naming of parts. Yesterday,| We had daily cleaning. And to-morrow morning, |We shall have what to do after firing. But to-day, |To-day we have naming of parts. Japonica | Glistens like coral in all of the neighbouring gardens, | And to-day we have naming of parts.' One might claim that the gun represents biomedicine, the natural history parts of the poem refer to the person-to-person qualities I describe.

> goodwilled we may be, we cannot take another's pain as our pain.
> Our pains divide us and there is little we can do to restore our unity.[132]

I think this is mistaken, for when our loved ones are in pain then we *would* bear their pain if that could be done. To say that genuinely and sincerely would I believe amount to an acid test for love. *We* would not wish to pass on our pain to those we love, yet that does not undermine the wish for us to bear it on their behalf when they are in pain. An example from general practice would be the child with ear ache in the middle of the night for whom treatments are too slow to work. Doctors see the parents wanting to do something, anything, to relieve the child's distress. Although not as engaged with the child as the parents, doctors might admit that the relief of suffering is not just a matter of analgesia, rather it is this standing by people in distress, and that applies to the parents as well as the child. Hauerwas does go on to say that this is very difficult, and I can support this view from my own practice, where one can feel wearied and crestfallen in treating the intractable pain of chronic disease, and then one might sense some distancing of oneself from the patient in view of the lowering effect on everyone concerned.[133]

We might call this *wise suffering*, for doctors tend to concentrate too readily on pain which can be relieved, leaving other suffering unaddressed. Sometimes they are dismissive of just that species of suffering which cannot be alleviated. Doctors perhaps see themselves as lifeguards on the beach, continually diving into the sea of suffering and pulling out those who are floundering, while acknowledging that others are beyond their reach and will be swept away. While we might all recognise that certain sufferings cannot be relieved, we need to recognise that, in the words of Hauerwas, 'Questions remain as to what kind of suffering should be accepted and how it should be integrated into our lives'.[134] Ignoring that question is a species of 'loss of problems' described earlier. Ramsey might have said that doctors need to show 'a certain fullness' in their dealing with patients, and that seems to capture the need for

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132 Hauerwas, 'Salvation and Health', 550.

133 Hauerwas gives the example of looking after a retarded child and the exhausting poignancy of that.

134 'We rightly feel that some forms of suffering can only be acknowledged, not transformed.' Stanley Hauerwas, 'Should Suffering be Eliminated? What the Retarded Have to Teach Us', in *The Haueras Reader,* 564.
Of practical concern is the warning form Hauerwas, 'work gives us a way to stay busy' R Reno, 'Working Toward Worship', in *The Blackwell Companion to Christian Ethics* ed. by S. Hauerwas and S. Wells (Oxford: Blackwell, 2006).

both clinical competence and capacity for compassion.[135] As with Job, we need to stand alongside that suffering; Aquinas gives an example of how we share that burden with others, both lifting their burden and showing our love towards them (ST I-II, Q.38, Art.3). In modern psychological terms we need to become aware of, and then to discard, any 'false front' which inhibits the manifestation of our virtues from the patients who need us to stand alongside.

In summary of this section, doctors need to be attentively and appropriately engaged with patients. They should stand alongside patients, acknowledging their suffering, and using all their professional and personal strengths to bring comfort and cure when they can.

2.1.8. Supererogation and Virtue

Giving our attention to each patient is a virtuous calling. This is difficult enough for the ordinary fulfilment of our duties, but even more so when we extend ourselves into supererogatory behaviour; it is when we are beyond our usual practices that we need to be very self-aware about our intentions and our motivations.

How can a doctor achieve the *telos* of medicine, which is not simply to diagnose illness, to treat and cure patients, but to care for them excellently? We look to the virtues to achieve that fullness. If we are to go beyond conscientiousness, acquire the virtues and reach a state of grace, then we should show pleasure to be with patients, and try to find pleasure in work, doing difficult things cheerfully.[136] Advice to patients to mend their ways might come later, offered with a due measure of diffidence. [137]

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[135] Ramsey, 197. Referring to St Paul: 'The fullness of which he spoke so confidently was, he believed, a certain fullness in God's dealing with men'.

[136] The grace of the father in the parable of The Prodigal Son is shown *before* his son's apology: 'But when he was yet a great way off, his father saw him, and had compassion, and ran, and fell on his neck, and kissed him'. St Luke 15. 20.

[137] It is impressive that in the BBC television series of lifeboats going out on 'shouts' to rescue people at sea, the crews take pleasure in saving life (including dogs and cows) and are clearly gratified to do so, reserving any words of advice until the rescued are safely ashore. https://www.bbc.co.uk>BBC Two>Saving Lives at Sea [accessed 1 August 2022].

How can a doctor acquire the virtues, and how does she take them to heart so that they become second nature? A good upbringing is foundational, and then we learn from following others, by modelling our behaviour on theirs (*mimesis)*; these small steps of apprenticeship grow in habit and strength. Jean Porter gives a convincing account of how children are brought up to be familiar with the virtues. [138] These become part of our *habitus*, that conglomerate of body language, bearing, and attitude to others. Doctors largely restrict their usage of this word to a patient's bodily gait and bearing, patients sense a doctor's *habitus* through all sorts of unconscious signals. This forms part of the reflexivity between doctors and patients: a bad *habitus* can set up barriers to communication even as the doctor enters the room, before she has approached the bed, and indeed despite her best intentions. This might explain how some consultations get off on the wrong footing and can never seem to be turned around; a bad *habitus* has muddied the ground.[139]

This emphasis on the virtues is justified, I believe, by the fact that *how* we work is more challenging for us than *what* we do. The *habitus* is so deeply engrained in us that we do not need to be told or to be reminded of what we should be doing: we mostly follow established routines, whether through following in the footsteps of others or by following codes of practice and published guidance. Such guides are plentiful. What is much harder to judge is how we are behaving to patients. In order to judge this rightly we need the ordinary virtues which we acquire in childhood, the usual interpersonal virtues which those who were born into loving homes tend to think are common to everyone and so find unremarkable. This is not to say that virtues may not be acquired in later life. The professional virtues are a top layer to this stratum and so tend to be more obviously evident on first meeting a doctor, but if the basal stratum, the foundation, is deficient then serious problems soon arise.

I am thinking of the daily inculcation of the virtues in children who are well brought up and who are able to benefit from their education. Such a long process of moral growth in childhood is imperceptible from day to day. This is a reliable process of

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138 Jean Porter, *Moral Action and Christian Ethics* (Cambridge: Cambridge University Press,1995), 174-176. As part of the recognition of ordinary obligation, students starting on the wards need to be shown how to warm their hands first before touching a patient's bare abdomen.

139 The rich complexity of the Christian habitus is described in John M. G. Barclay, *Paul and the Gift,* (Grand Rapids, MI: Eerdmans: 2015) 493-519.

accretion, something slow but steady, unlike those more spectacular, Damascene conversions which abide in our memories.

2.1.9. A Physiological Calling

The episode with Dr Robinson Crusoe is intended to show the foundations I wish to explore. These foundations, much obscured by our professional way of being, are made up of person-to-person obligations independent of our professional duties, and they are further compounded with what I shall name the *physiological calling* patients radiate out to us when they are ill and distressed.[140] Such levels of need and response are examined by Emmanuel Levinas whose work is described in Chapter 4. This calling is utterly basic, appearing most when people cannot help themselves, and it should never fall on deaf ears. An example would be our sharing food with strangers when they are hungry. I see this calling as originating in the perceived needs of others, especially when they are injured, ill or distressed, and it is an integral part of our humanity. Young children readily display it, becoming distressed when others around them are crying; adults show this emotional contagion, laughing when others are laughing, even when they did not understand the joke which provoked it. It is particularly relevant for doctors who should offer basic care and try to comfort those who are in pain.

I am not the first doctor to recognise this fundamental call: Ann Sirek, a practising doctor who has studied theology, especially *Summa Theologica*, makes a call for the basic approach of attending to the suffering of patients, alongside them, not viewing them from above.[141] The perennial psychological difficulty is that for effective treatments to be found and safely administered, then we have to leave that state of being and use all our intelligence and investigative powers to find a remedy; that of course means we enter a psychological 'adult' state and can become detached from that fundamental appeal. How we handle that difficulty is a sign of maturity, for loving attention to another may well require some temporary distancing. The so-

[140] It is now believed that bodily reactions of distress precede the felt distress of emotions, and that seems to indicate a primary physiological reactivity.

[141] Ann Sirek, *Visceral Resonance: A Theological Essay on Attending the Sufferer* (Eugene, OR: Pickwick Publications, 2000).

called Child, Adult and Parent ego-states (the spelling starting in upper case) refer to terms used in Transactional Analysis, a psychological study of how we interact and influence each other.[142] Virginia Woolf, in her essay *On Being Ill* (1930),[143] referred to the child-like state we are reduced to by illness (with the doctor being seen as a parental figure). That relationship between Child and Parent states requires a high level of maturity from the doctor to be handled wisely.[144] The doctor needs to be virtuous, to navigate a difficult journey through all three states so that he can feel the patient's suffering as if he were a child, bring comfort as if he were the parent, and use the resources of biomedicine in an adult state. We are to stay alive to the suffering of patients, and not to show hardness of heart by focussing too much on our own safety, as illustrated by doctors fleeing from the danger of infection. This is primarily the cardinal virtue of fortitude.

2.1.10. Conclusion to Part 1

This first part of this chapter points to the important claim that doctors remain both doctors and persons, both in and out of work, and that we should not make a fundamental distinction between our professional duties and our ordinary obligations. We might put aside our medical skills when we are off duty but we cannot discard them, and we always remain in relationships of ordinary obligation with everyone. I have concentrated on the felt experience of illness in this chapter so far, and in the next part I wish to look at duty and obligation in a more analytical light.

Part 2: Modern Philosophy and Obligation

2.2.1. Introduction

In this second part I show how two distinguished modern philosophers, Bernard Williams and Alasdair MacIntyre, have approached morality, especially in relation to

142 Eric Berne, *Games People Play: the Psychology of Human Relationships* (Harmondsworth: Penguin, 2016)
143 Virginia Woolf, *On Being Ill* (Ashfield , Mass: Paris Press, 2012)
144 Paternalistic behaviour from doctors likely has its origins here.

duty and obligation. I then attempt to recreate our doctor's experience when he is confronted by the need to extend himself beyond his usual activities. I hope to show that supererogation can be settled on a basis of generosity, and I illustrate this by reference to historical doctors.

2.2.2 Bernard Williams

One of the most penetrating critics of the idea of moral obligation is Bernard Williams. In *Ethics and the Limits of Philosophy*,[145] he describes his objections to a life dominated by morality, especially when we are dragooned into submission by the force of moral obligation. One of his complaints against 'the Peculiar Institution'[146] of morality concerns the oppressive domination of obligations and the pushing away from consideration of other non-moral factors which might well be more important to the individual. One consequence of this is that the morality system short-changes those important elements of life to which obligation cannot be attached but which are so important in making our lives *human.* For example, in the last century admission to medical schools was tilted towards those applicants who were 'good all-rounders', especially those young men who were good at rugby as well as academic pursuits. In view of the demanding nature of the medical life it seems wise to recruit those people who are well-balanced with a broad range of interests.[147] The oppressive hegemony of obligations is why supererogation came to be pushed to the margins of philosophy and theology,[148] an effect lasting for centuries, from its silencing by the Protestant reformers up to the mid twentieth century, when Urmson allowed the topic to find its voice again.

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145 Bernard Williams, *Ethics and the Limit of Philosophy* (Abingdon, Oxon: Fontana, 2006), first published 1985.

146 Williams, *Ethics*, the title of chapter 10.

147 On the morning of 6th May 1954 Roger Bannister left off his medical research in London to catch a train to Oxford where he took part in the race which resulted in his running a mile in under four minutes. I sense that Bernard Williams would have approved of such a break from the duties of research.

148 Kirk quotes from Canon Hannay to give a description of the changes which brought this about: 'The general tendency of Protestantism has been to raise to a high level the common lives of citizens. It has not made for, and except in comparatively rare instances, has not achieved, the production of unique saints . . . . This failure must be attributed to the denial of the doctrine of 'counsels' and 'precepts', and the consequent unwillingness of Protestant teachers to hold up for admiration lives which must always be rare, and are never imitable except by those who realize the peculiar glory of very great kinds of renunciation . . . . Thus Protestants theologians . . . . have deprived Protestants of an incentive to a lofty kind of life'. Canon Hannay in J. Hastings (ed), *An Encyclopaedia of Religion and Ethics* (13 vols 1908-1926), p.205. Quoted in Kirk,520.

Williams asks, 'How does the morality system deal with the considerations that seemingly do not yield obligations?', and he mentions those actions which 'may be heroic or very fine actions, which go beyond what is obligatory or demanded' [149]. His main target was based on the philosophy of Kant and the abstract reasoning of the Utilitarians. These philosophies are concerned with what we should do, not about the sort of people we should be. Williams had a particular dislike for the abstract, impartial nature of such theories; he disliked their hands off, depersonalised quality.

In a commentary on Williams by Charles Guignon[150] the baleful influence of *methodologism* is brought to attention. This is the idea that our thought and behaviour can best be understood by likening it to the natural sciences; in particular we come to see ourselves and others as 'basically disengaged subjects'; we are 'only fully rational when we act according to statable, justified principles'.[151] This disinterested approach is suspect and unreal, especially from the point of view of supererogation, when agents are personally engaged with what they are doing. Guignon interprets Williams' distrust of methodologism as hiding 'other crucial dimensions of life, dimensions such as meaningfulness, importance, supererogation, the place of care, the role of dispositions, the possibilities of nobility and the heroic, and questions about what we ought to *be*.' [152]

In a similar vein, Charles Taylor supported Williams. He too condemned the importance accorded to morality which he thinks 'is characterised by a terrible constriction of ethical thinking'.[153] He notes the distortion of our moral experience based on obligation:

> Williams points out how distortive this is of our moral experience.
> For one thing, this system has no place for acts of supererogation.
> We admire people for great acts of courage, or self-dedication,

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149 Williams, *Ethics,* 179.
150 Charles Guignon, *Williams and the Phenomenological Tradition in Reading Bernard Williams,* ed. Daniel Callcut (Abingdon: Oxon, 2009), 166-168.
151 Guignon, 169.
152 Guignon, 171.
153 Charles Taylor, 'A most peculiar institution', in *World, Mind and Ethics, essays on the ethical philosophy of Bernard Williams,* ed. by J. E. J. Altham and Ross Harrison (Cambridge: Cambridge University Pres, 1995), 133.

> and all the more so just because they were under no obligation to do these.[154]

Traditional ways of thinking about ethics, especially in the naturalistic mould, envisage the business of ethics as deciding what *actions* we need to do. Williams and his commentators, on the other hand, emphasise what is *important* for the individual who is trying to make a choice. Furthermore, naturalism cannot accommodate states of mind which do not contribute to this emphasis on action. We could see the category of supererogation, along with the 'noble and heroic' as mentioned above, as just such items of furniture of the universe which cannot be accounted for by naturalism. Moral philosophy's disregard of such states of being, acting and feeling has had peculiar consequences: there is undue emphasis on action, while aspirational states of character improvement tend to be disregarded. With these analytical concerns in mind, let us now see, in the next section, how supererogation might be incorporated into medical practice.

2.2.3 Distinguishing Duty from Obligation

I believe that some doctors have lost sight of obligations, and have focussed instead on professional duties to patients By moral obligations one to another I mean those diffuse, ill defined callings upon us to respect the vulnerability of others and to help them where we can. Furthermore some doctors have given these duties a formality and sense of importance which carries the day. Moral obligations have not been subsumed within duty but pushed to one side. Although many philosophers and theologians think of duty and obligation as synonymous, for the purpose of this thesis I propose separating them in order to make my argument clearer. My wish is for doctors to achieve some sort of fusion of duties and obligations so that we are whole.

By contrast, the professional duties of doctors to patients have been constructed to confirm and strengthen our view of ourselves in relationship with patients and society. There is a cleavage between moral obligation and professional duty, and also a cleavage between patient and doctor. In cases of such marked divergence we are far removed from the person-to-person state of Dr Crusoe and Mr Friday; by contrast, in

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154 Taylor, 132.

our complex interrelationships, and in our interactions with administrative systems and institutions, our moral obligations have hardened and grown cold.[155] Such doctors become more efficient in technical skill yet ever more remote from the humanity of the patient and knowledge of themselves.[156]

We might use an analogy from language learning to illustrate what has gone wrong. By being too much in role, too much identified with professional duties, doctors are in danger of forgetting their moral obligations. When learning a second language we rarely achieve the fluency of our mother tongue; indeed it is hard to gain the subtlety of expression of our first language. That is how doctors can become stiffened with a lowered 'horizon' of view, for the language of moral obligation is our first language; professional language is learned afterwards. The fluency and richness of our maternal tongue should be a template to which our second language aspires. I suggest doctors need to be in dialogue with patients to get to the heart of the matter, but also in continual internal dialogue in order to bring about an ever closer rapprochement between moral obligation and professional duties.

2.2.4 A Damascene Conversion

Defoe examined the nature of moral obligation between Crusoe and Friday on the desert island. By contrast let us now look at the mixture of moral obligations and professional duties in a doctor working in a busy modern hospital. I describe a scenario based on my experience as a student:

A consultant doctor takes some medical students to see seriously ill patients who have recently been admitted. He sees himself as having not just a pedagogic but a protreptic function too.[157] *He wants them to think as broadly as they can about medicine, not just its surface or technical activity. The students come up with all sorts of proposals for treatment based on the latest discoveries and biomedical technology. The doctor emphasises the need for fundamental care, and in view of the loss of*

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155 'The sunlight on the garden hardens and grows cold' from the poem of that name by Louis MacNeice (1907-1963). It concerns hardness of heart.

156 The *techne* of ancient Greek philosophy versus *episteme*.

157 *Proprepticus*, a lost work by Aristotle, concerned with the encouragement to study at a deeper level, especially in philosophy.

weight of the patients, he says that basic human goods, especially good nutrition, come first and foremost: they will not recover without it.

Afterwards he goes to the canteen for lunch, but a strike has been called. No food is being served; sandwiches have been prepared for the patients but the porters refuse to take them to the wards. Does he offer to take the sandwiches to the ward himself, and how does he expect the students to respond? How seriously does he put into place his values and his advice to the medical students?

A parallel situation arose at the medical school I attended as a student and has given me pause for reflection on many occasions since then.

A doctor might believe that taking food to the wards is not his concern: it is not part of his contract of employment, and it is the responsibility of the hospital manager to find a solution, though solidarity with the striking porters might well enter into this thinking He is too busy himself to take food to the wards for he has to prepare for the afternoon clinic. As with the doctor driving past the scene of an accident, we tell ourselves that there are plenty of other people who might be called upon.[158]

Mulling over the situation later in the day, he recalls what he said to the medical students, and in a Damascene moment he undergoes a conversion in belief. He had been thinking of his wife and children when he was seized with the conviction that he could not bear to think of their going hungry, especially if they were unwell. The idea struck him that a person who lets others go hungry was not the sort of person he wanted to be.

If we return to the list of qualities identified by Guignon, those 'crucial dimensions of life' which include supererogation, then we can see that such qualities are usually hidden from view by the busyness of ordinary quotidian life, something which consumes our energies and preoccupies our thinking. I am trying to show how moral obligation can so readily become detached from professional duties, and how the latter tends to take precedence over the former. A doctor might be attracted by

[158] Jonathan Glover, 'It makes no difference whether or not I do it', in *Applied Ethics,* ed. by Peter Singer (Oxford: Oxford University Press, 1986), 124-144.

supererogation but be fearful of the continual accretion of the supererogatory into the dutiful. There is a danger of this if we pursue the supererogatory with any zeal. We can see at once that what we could call 'quantitative supererogation', that is simply working ever harder and for longer hours, would lead to exhaustion;[159] but what about 'qualitative supererogation', working to every higher levels of attainment in intellectual and imaginative ways? That seems more promising.

On further reflection the doctor believed that he should have offered to take food to the wards, notwithstanding that it was not a professional duty and that others might have done so. Initially seen as an example of supererogation, it now suddenly seemed a moral obligation to which he should have responded, in accord with the 'certain fullness' he wished to bring to his working life. He believed he had narrowly passed by on the other side, unlike the Good Samaritan who treated the injured man as his brother; the doctor had shown himself to be a hypocrite in the eyes of his students.

What do doctors want from their working lives? As well as material rewards, I suggest they want to work as well as they can, keeping up to date, and enjoying a good reputation. But the intangible desires are there too: a deep level of satisfaction at what they are about; carrying out professional duties in the light of their moral obligations. We want a coherence to exist between our professional duties and our moral obligations.

If professional duty could be compared to the trunk of a tree, obvious, solid and strong, then according to the 'duty plus' model supererogatory acts could be seen as the flowering branches above: readily noticeable and attracting the admiration of passers-by. Before his Damascene conversion the doctor seemed to think that taking food to the wards would have resembled that blossom on the branches. Now seeing things in the new light of his own family going hungry, providing food for others seemed not like the showy blossoms, but like the roots of the tree: underground, out of sight, and essential of course for the life of the tree itself. It is better to look down

[159] In George Orwell's *Animal Farm,* the horse Boxer states, 'The solution, as I see it, is to work harder'. The poor simple beast is exploited by the new masters, the pigs, and is sent to the knacker's yard when too exhausted to work.

at the earth, not up at the sky.[160] We have to dig down into ourselves to find contact again with the fundamental needs of others; we need to clear away layers of sedimented responses which have buried the fundamental needs of patients under working habits, professional requirements, and the busyness of being in role.

We learn such sedimented responses from our predecessors, so our view of patients is conditioned by the way earlier generations of doctors saw them: we see our patients partly through *their* eyes. In addition, life obscures our emotional responses and dulls down our empathy by the exigent demands of getting through the working day. Daniel Defoe's perception reveals the primacy of these earthly roots, clearing away the soil which hides them. Living in society, surrounded by others, allows us to overlook the connections between all of us: out of sight, out of mind.[161]

2.2.5 The Quality of Professional Life: MacIntyre and Tradition

I also take note of Alasdair MacIntyre who, though very different from Williams, also focuses on the felt quality of moral obligations. Now most associated with his study of the virtues, *After Virtue,*[162] it is easy to overlook the extensive contribution he made to the study of medical ethics in the earlier part of his career. A review article of his work in this area has recently been published. [163] He was pessimistic about medical ethics generally, thinking that problems in medicine could not be solved until doctors and patients shared the same moral language, and thus his work could be seen as a pointer to the 'Loss of Problems' I have described in the Introduction to this thesis. He also wrote on the fragmentation of moral views, the internal goods of medicine, and the virtue of doctors, among other topics of concern. In *After Virtue,* he identifies the foundations of ethics as threefold in nature: 'the conception of untutored human

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160 Offering a meal to our enemies might be seen as supererogation, as with Madame le Trocmé in Chapter 1, yet it might better be seen as providing for the basic needs of others in as ordinary a way as we can.

161 It is now believed that trees communicate with each other by chemical signals given off from the roots.

It is the press of people in *A Journal of the Plague Year* which gives some sort of psychological permission for doctors to flee their post. We seem much less likely to abandon individuals in small groups. The paradox of the heap seems applicable here, when individual patients become so many as to form a population, or a study group in a clinical trial.

162 Alasdair MacIntyre, *After Virtue,* (London: Duckworth, 2006), 238-243.

163 Patricia S. V. C. Pastura, Marcelo G. P. Land, 'Alasdair MacIntyre's writings on medicine and medical ethics', *Revista Bioethica* 27(4) Oct/Dec 2019. E pub Jan 10 2020.

nature, the conception of the precepts of rational ethics and the conception of human-nature-as-it-could-be-if-it-realized-its-*telos'*.[164] In this respect one can see that by shifting the focus of its *telos* from care to cure, the foundation of biomedicine has become unstable because cure cannot always be achieved. Despite the grand achievements of modern medicine, cure is better regarded as an intermediate goal of medicine, not the destination or *telos*; there is a danger of the neglect of care if cure cannot be achieved. In recent years the conception of a *telos* of medical practice has been further destabilised. The appetite for cosmetic surgery, for example, has led some surgeons to perform questionable procedures. An extreme example of a surgeon exceeding traditional approaches to cure or care occurred when a surgeon acceded to patients' request to have amputation of non-diseased limbs. This has been done for patients with apotemnophilia, a rare form of Body Integrity Identity Disorder.[165] The *telos* of medicine is thus a contestable issue in modern society.[166]

One way forward in such dilemmas would be for society to look for a broader approach from doctors, and MacIntyre looks to literature as a source of human enrichment. For example, he points out that Jane Austen took as a foundation of morality that we should feel in the right way and bring a decent sensibility to our affairs; in other words we cannot act rightly if we do not feel rightly. In my view feeling gives rise to cognition, as we have seen when the doctor comes upon the empty canteen after the ward round.[167]

MacIntyre was interested in such a process; he was mindful of the nature of the traditions in which we work, believing that if we are to go further than the accepted standards of the day then we have to learn from and build on tradition. His emphasis on tradition was developed in *Three Rival Versions of Moral Enquiry.*[168] He names

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164 MacIntyre, 53.

165 Such amputation of apparently healthy limbs was banned in 1997 after a Scottish surgeon operated on two patients; there was an understandable outcry.

166 Toni C. Saad, 'Mistakes and Missed Opportunities regarding Cosmetic Surgery and Conscientious Objection', *Journal of Medical Ethics,* 44(9) (2018), 649-650. He writes against the so-called Principle of Patient Preference Absolutism.

167 Sensibility between patients and doctors, a sort of getting things off on the right footing, has been studied by James C. Edwards who interprets the work of Wittgenstein. James C. Edwards, 'Religion, Superstition and Medicine', *Slow Cures and Bad Philosophers,* ed. by Carl Elliott (Durham: Duke University Press, 2001), 29-30.

168 Alasdair MacIntyre, *Three Rival Versions of Moral Enquiry* (Notre Dame: University of Notre Dame Press, 1990).

the versions as follows: The Encyclopaedist, The Genealogist, The Traditionalist. These have been studied in turn by Gordon Graham who states that 'All human practices can be thought of in this way'.[169] I now intend to apply these ideas and see how they might influence doctors. For the Encyclopaedist doctor, medical knowledge would be 'progressive and accumulative';[170] knowledge gained would simply keep growing. Deference to such a massive structure of medical knowledge accumulated over the centuries could be expected (one thinks of the deference to the works of Galen in earlier times). The Genealogist doctor, by contrast, would not see such a benign growth or that knowledge was always beneficial, perhaps seeing truth only as a function of power. This doctor would be much more concerned with the power structure of the profession versus patients. The Traditionalist doctor would be mindful of the historical conditions which preceded her own practice, she would 'see the pursuit of understanding as requiring not merely knowledge of membership of that tradition' and with an overall working towards 'coherent self-understanding'.[171]

Following MacIntyre's lead, I see the Traditionalist as the most appealing of the three. The Encyclopaedist would, I think, show a disengaged, paternalistic approach, putting the truth of medical science before the inclinations of the patient. The Genealogist would take pains to avoid paternalism, suspecting that the notion of professional authority leads to unwelcome domination; 'true from a point of view' might be the Genealogist's mantra.[172] He would perhaps not give the clear guidance required by patients faced by difficult choices, deaf to the invitation of, 'And what would you do, doctor, if you were me?'. That sounds like an appeal for help rather than a simple request for information, the tone more person to person than patient to doctor. Why does the Traditionalist approach seem the most appealing of the three? MacIntyre is pointing the way by taking the best from the first two approaches while rejecting their faults:

> The authority of a master is both more and other than a matter of exemplifying the best standard so far. It is also and most importantly

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169 Gordon Graham, 'MacIntyre's Fusion of History and Philosophy', in John Horton and Susan Mendus (eds) *After MacIntyre Critical Perspectives on the Work of Alasdair MacIntyre* (Cambridge: Polity Press, 1994), 168.
170 Graham, 168.
171 Graham, 168.
172 MacIntyre, (1990), 43.

> a matter of knowing how to go further and especially how to direct others towards going further, using what can be learned from the tradition afforded by the past to move towards the *telos* of fully perfected work. It is thus in knowing how to link past and future that those with authority are able to draw upon tradition, to interpret it, so that its directedness towards the *telos* of that particular craft becomes apparent in new and characteristically unexpected ways.[173]

This important approach suggests a dynamic way of being, drawing on the past accomplishments of a craft, combined with a probing attitude to the future, willing to incorporate new elements into the scheme. Later in the text he writes of 'finding a place for oneself as a character in the enacted dramatic narrative which is that story so far',[174] and the sense of narrative implies an unfolding story which is continually being added to by new discoveries and new ways of approaching patients.

There is no talk here of duty, rather MacIntyre focuses on *telos*. If his interpretation of the craft of medicine does point the way to supererogation then it is not something settled on a basis of duty but on the basis of generous giving. This view enables doctors to construct the medical world themselves, a world which is mindful of duty but which fully incorporates patients' concerns, their illnesses and doctors' own responses. The distraction of demarcated boundaries of obligations, duty or contractual requirements thus falls away. MacIntyre was interested in this 'type of knowing', and I think this also, as with Williams, points to a loosening of our way of seeing, away from the notion of defined duties and obligations, more into a creative way of sensing what is called for in each situation.

One can go further into this 'type of knowing'. MacIntyre shows that professional duty and moral obligation are in reality intertwined, indeed barely distinguishable. Furthermore, our duties cannot be pursued without regard to virtuous intention and performance, indeed duty becomes incoherent if not done virtuously (it would seem strange to think otherwise). This idea is supported by my claim that the worst failures of medicine in the twentieth century stem from the divorce of the two. In their concentration camp 'selections' and medical experiments at Auschwitz, a perverted 'duty' was zealously pursued by Nazi doctors with overwhelming cruelty; but even

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173 MacIntyre, 65-66; reprinted in Graham, 168.
174 MacIntyre, 65; reprinted in Graham, 169.

failures in the civil law show doctors pursuing their duty while blinding themselves to the requirements of virtue. The Tuskegee scandal revealed doctors pursuing their research agenda into patients with syphilis, all the while oblivious to their wishes and deceiving them as to their own intentions.[175] The doctors involved in the study seem not to have been wicked, but to have been blinded by their desire to find an answer to a question in public health. MacIntyre claims that virtues have to be 'internal' to practices and if this were taken to heart by doctors then failures such as Tuskegee might be averted. For example, single-mindedness might be a virtue, but *not* when the *telos* of medicine is ignored: the individual patient has to be held at the constant centre of attention. Such blindness is the result of being blinkered in the pursuit of medical knowledge.

In this thesis I am proposing that doctors should combine duty and virtue in inventive ways to stop themselves sliding into vice. Duty and virtue are not to be seen like business partners who might vote against each other in some enterprise, but rather as conjoined twins who depend wholly on each other. We might better say that we only find fulfilment in our work if done virtuously, and we can clearly see that the findings of medical research done without virtue become vitiated and suspect. Similarly, we cannot claim to be virtuous is we have not done our professional duties as well as we can.

2.2.6 Dr William Withering and the Foxglove

An example of this creative way of sensing what is called for, showing the precepts of rational ethics infused by virtue, can be seen in the life of William Withering (1741-1799), whose book, *An Account of the Foxglove and some of its Medical Uses* (1785) is a classic of medical literature.[176] He describes over 150 patients to whom he administered digitalis, extracted from the foxglove plant, and which is still used in the

[175] At Tuskegee, Alabama, a study began in 1932 to track the natural history of syphilis in black men. No treatment was offered but they were told they had 'bad blood' and that they needed follow-up. Many of the men wanted to join up during the Second World War but were declared unfit after intervention by the doctors conducting the study, even though newly available treatments would have cured them. The study lasted until 1972. In 1997 President Clinton apologised and called it 'shameful'. Susan M. Reverby, *Examining Tuskegee: The Infamous Syphilis Study and its Legacy* (Chapel Hill: University of North Carolina Press, 2009).

[176] Porter, 270.

treatment of heart failure, or 'dropsy' as it was then called. Preparations of foxglove had been in use for many years, both in medical practice and as a constituent of folk remedies, but Withering's approach was new: he acknowledged and listed historical usage; he sensed that dosages were too high (causing vomiting and diarrhoea) and so he regulated the strength of preparations; he gave experimental doses to animals; he recorded his observations and found patterns emerging. Withering collated all this information and was thus able to make sound recommendations for use.

This is in accord with MacIntyre's description of the Traditionalist approach, with its respect for past practitioners coupled with new ways of looking at an old remedy. But we can also find supererogatory elements in Withering, with that mixture of moral and non-moral features which appealed to Williams. Withering earned a fortune from practice, travelling long distances to see patients at home; he also treated between 2,000 and 3,000 patients annually *gratis* at Birmingham General Hospital, and he continued to work until the day before he died. He was also a member of the Lunar Society (along with Joseph Priestley) and studied geology and botany. In other words he was generous with his time and energy, the well rounded and hard working doctor who was keen to publish his findings. His story illustrates how difficult it is to distinguish between duty and supererogation, for benefit to others was intimately tied to benefit to himself.[177]

It might be said, and it is a feature of doctors like Withering, that the boundaries of duty are continually being exceeded, so much so that the boundary between duty and supererogation becomes blurred. Withering died of consumption, and we could say that he worked so hard as to be consumed by his duties, however we might prefer to say that his duties had been consumed and surpassed by his research and practice. He was acting out his own 'dramatic narrative', both actor and director of his own creation. He added to medical knowledge and pointed the way for others. The fact

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[177] A direct, altruistic benefit to the patient *seems* to be required if we are to call a doctor's behaviour supererogatory, but this is at variance with Swinburne's comments about the difference between 'favours' and 'creative acts'. Swinburne writes that it is good (supererogatory) to write poetry rather than to watch television, even though only the author reads the poems. He claims that non-altruistic acts can in fact have a diffusive effect on the community as a whole. Richard Swinburne, *Responsibility and Atonement* (Oxford: Clarendon Press, 1989), 23-24.
Withering's researches have brought both immediate and long term benefit to patients, and this lends support to Swinburne's sense of indirect benefit to others.

that his work is still relevant shows a central concern of MacIntyre, that the ends and means of practices should cohere is a satisfying way, and that integrity starts to unravel if these two features are not in conjunction. Withering showed the quality of *phronesis*, that happy application of the intellect in the pursuit of practical wisdom.

Another way of looking at doctors such as Withering, with their manifest interests and enquiries, is to think of them as demonstrating 'a plenitude of ends'. This expression, from Kant, denotes the many possibilities of desires, dreams and ambitions which we experience in all their fullness, at least imaginatively, and from which our actual accomplishments take shape. In this regard we start off very broadly, beguiled by possibilities, with unformed ideas of what we hope to achieve, and narrow down to the notion of duty; in that movement from expansiveness to constraint can be seen a reduction of our desires. As Christopher Insole points out in his work on Kant,[178] we normally think of moving from the simple to the complex, as illustrated in our ideas about evolution; so this movement from a plenitude to the modest, a feature of the intellectual history of the pre-modern world, is a reversal of our usual way of thinking. In this pre-modern view, duty could thus be seen as just 'a derivative shadow and emanation' of those inchoate wishes,[179] solidified into shape from that plenitude of primeval elements. Supererogation, I suggest, appears as short-lived, rebellious escapes of those wishes from the binding constraint of what we can achieve in practice. With this in mind, we might think of duty as being formed from the energy and primeval particles of our generous wishes, just as the sun was formed from the energy of the cosmos. The fulfilment of duty by others keeps us safe, just as the sun makes possible and sustains life on earth, so acts of supererogation might be thought of as solar flares: sudden, short-lived, unpredictable events, releasing enormous amounts of energy. If we accept that generosity should be the foundation of our interactions with others then duty could be seen as a *reduction* of what we might hope to achieve, but it is only by focussing and compressing our inchoate wishes into the constraint of duty that we can realise our potential. Support for this approach comes, I believe, from comments by Adam Smith about the rather blunt

178 Insole, chapter 2.
179 Insole, 18.

nature of duty: his keen interest in moral psychology shows how duty needs to be dressed with other qualities such as amiability and gratitude.[180]

I have looked closely at Dr Withering because I suggest that a study of his life would have been of interest both to Williams and to MacIntyre. For Williams he showed that mixture of the obligatory and non-obligatory elements in his life, the one invigorating the other in a creative, generous way. For MacIntyre his work shows the strong established foundations of good practice, all focussed on the *telos* of medicine. Withering kept his patients constantly in view and was not dazzled by his own achievement, working for others in this hybrid way of dutiful and supererogatory elements, a creative intertwining which becomes its own reward. With this in mind I now wish to look afresh at the foundations of supererogation.

2.2.7 A Stronger Foundation

The study of Dr Withering, especially in the light of Williams and MacIntyre, enables me to shift the foundations of supererogation. We noted in Chapter 1 how Heyd placed supererogation on a foundation of duty, and he argues strongly for this. He makes the following statement in describing a doctor who goes to a plague-ridden city:

> He goes beyond his natural duty, being concerned with the welfare of others to a greater degree than may be expected of him. The supererogatory element in his praiseworthy act lies not so much in his action *as a doctor*, but rather in his action *as a man* (who happens to have a highly relevant skill).[181]

I think Heyd is making an important mistake here, and it stems from the perceived division of ourselves into a person on the one hand and a doctor on the other. I prefer to find no such division within us, nor to begin to see ourselves as easily divisible, for

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[180] 'Though a son should fail in none of the offices of filial duty, yet if he wants that affectionate reverence which it so well becomes him to feel, the parent may justly complain of his indifference.' Smith, 260.
In *King Lear* Cordelia is provoked by the fulsome thankfulness of her sisters to state that her love for her father results from her duty to do so; her stark lack of sentiment provokes her father to rage, and the tragedy results from that.

[181] Heyd, 135.

then the 'doctor' part of ourselves might come to be seen as just a 'skill-set'. I wish to promote the idea that we are whole beings, that we should see all of our activities as coherent. This coherence within us is important, both because of the harm that arises from the blinkered pursuit of duty when the virtues have been abandoned or have become perverted, and because there is a fundamental mistake in seeing ourselves broken up into parts. Of course we might say, 'Speaking as a doctor, I would advise you to think about this', but this is usually a conversational device to hide our feelings about a patient's proposed course of action, or a form of words which distances us from the discomfort of the person we are addressing. Patients want the doctor to speak both professionally and as someone who is personally concerned; they do not want to sense tension within doctors who sound evasive or guarded, hedging their bets. Patients want the whole person of the doctor they are consulting to be engaged with them, to see each person in the round, not just as a patient with problems or a difficult 'case' of disease.

Why is this important? Heyd takes issue with Feinberg and his focus on the 'over-subscription' model; it is true that a focus on obligation as a list of duties, outlined on a work sheet of jobs to be done, does not get to the heart of the issue. Both Feinberg and Heyd are striving for something deeper, but seem to get stuck on this issue of the foundations. By settling supererogation on a base of duty, Heyd has difficulties with his proposed 'taxonomy': he has to trim and finesse his argument in order to accommodate his paradigm cases.[182] I propose generosity to be a stronger foundation for the concept, chiefly because it arises from within us and is not dependent on anything imposed upon us; it thus avoids the fuzzy boundary lying *just* beyond duty which makes judgements of actions difficult. Also generosity is a better basis for acts such as gifts, e.g., the donation of blood, where there is neither a formal nor a societal contract in place. It is true that generosity is a vague foundation, but its vagueness is a strength not a weakness. I am thinking of Aristotle's *Nichomachean Ethics*, and his deprecation of seeking for a precision which is inappropriate for the condition being studied. [183] The foundations are better left in this state, just as the

[182] These are 'saintliness and heroism, beneficence (charity, generosity, gifts), favours, volunteering, supererogatory forbearances, and finally pardon (forgiveness, mercy)'. Heyd, 142.
[183] Sven Ove Hansson, 'Precision in Philosophy', *Theoria,* 78 (2012), 273-275.

manifestations of supererogation are themselves vague, as will be described in the following paragraph.

With this blurring of the boundary between duty and supererogation in acute situations and research activities, it might seem that the vagueness of the concept makes it hard to pin down, at least in the medical setting. And it is true that the *felt* quality of medical life is not one of clear demarcation of where our duties begin and end. I remember giving mouth-to-mouth resuscitation to a patient. This is normally done with a bag and mask which fits over the patient's mouth and nose, but equipment was not to hand and so, in view of the urgency, I placed my mouth over his mouth and breathed into his lungs, clutching his nose. He had recently vomited and particles of vomit and the acrid taste came into my mouth. This action, then and now, did not seem to me to be 'beyond duty'; that is, the *felt* experience simply called for it to be done. [184] As with Dr Rabbeth, the action had not been spelled out in any list of duties, yet I felt impelled to act as I did, irrespective of what professional duty might have called for. Of course a passer-by on the street might have balked at giving mouth-to-mouth resuscitation to a stranger who had vomited and collapsed, and that failure of supererogation would not deserve criticism; however in the intense setting of resuscitation on a hospital ward we are thrown back onto the primitive responsiveness of Dr Crusoe and Mr Friday, that one-to-one quality: *I* had sole command of his airway, the others did not, and that made all the difference. My professional duty had put me in charge, and therefore in a position to behave in a way that was part of my duty and yet inseparable from a moral generosity.

2.2.8. Conclusion

In Defoe's *Robinson Crusoe* the nature of what we owe one another *ab initio* was examined. My allegory of *Dr* Robinson Crusoe shows how professional duties are subsequent to moral obligations ('care before cure' might be an appropriate catchphrase). I have outlined further the difficulty of discerning where obligations

[184] This might be called a practical necessity based on the practical syllogism: x wants to resuscitate the patient. Unless x blows air into the patient's lungs he will not succeed. Therefore x has to apply his mouth to the patient's mouth. This seems to side-step the question of duty and supererogation. Adopted from von Wright, 167.

begin and end by looking at the responses of an imaginary doctor and how he behaves during a hospital strike. Williams' distrust of morality was described, and I also discussed Taylor's belief that we should incorporate 'higher goods' into our lives; this underlines the need to rank our desires and duties. MacIntyre stressed the inherited tradition of our professional life, how we follow in the footsteps of predecessors and we should try to incorporate their moral goods in a new whole. Both Williams and MacIntyre seemed to be widening our remit, with Williams looking at what is *important*, independently of formal duties, and MacIntyre settling our activities on a very broad base. MacIntyre's comment about going further seems to open the doors of professional duties onto new areas of life which then become incorporated into quotidian activity. That was illustrated by the 'fully perfected work' of Withering.

What I am trying to promote is a sense of supererogation pointing us in the direction of professional and personal excellence, leading us to transcend the narrow rectitude of duty and to focus again on the *telos* of medicine. This is intimately bound up with both technical excellence and a humane, imaginative sense of what more might be done for patients.

I stated in the Introduction that supererogation is waiting in the wings for doctors, and I have found that for the modern doctor described above, and for the modern philosophers too, the place of supererogation in medicine has not yet been clarified. Why this has not taken place is of great importance, and I suggest that supererogation was lost sight of after the mediaeval period because of a decline in the influence of Aquinas along with his adoption of the teleology of Aristotle. In the next chapters I try to discover how this took place in the centuries from the end of the mediaeval age until the twentieth century.

3. Chapter Three: Loss of Supererogation: Professional Development and the Rise of Good Sense

3.1 Introduction

I described the Beyond Duty model in chapter 1, and found it to be too restrictive to embrace an understanding of supererogation arising outside dutiful settings. This was followed by an explanation of the concept of supererogation in medicine in chapter 2. I showed that supererogation has no secure place in modern medicine. In order to give it a better foundation, and to place in context changes to be described in later chapters, I now try to track the disappearance of supererogation from medical practice, its falling out of sight. This change led to the hegemony of duty in medical practice. This was caused chiefly by the ideas of the Reformation, and then later by the growth of professionalised medicine. I show how professionalisation led to a narrowing of doctors' attitudes and behaviour, with a growing sense of their own authority and autonomy. This resulted in defensive behaviour and the erection of boundaries, devised to exclude unregulated practitioners from the profession.

The rise of moral sense, leading into 'good sense' as a way of looking at life, became prevalent in the eighteenth century, and novels of the period illustrate this reasonable attitude. I will show how it was an attitude unsympathetic to supererogation, leading to an idea of medical practice being properly grounded, not in sacrificial service to others, but in scientific progress and dutiful pragmatism; these influences still shape our understanding. We could say that supererogation in medicine was not actively pushed away, rather that it lost any sense of importance for doctors.

I then describe the codification of medical behaviour and how remote such codes now seem. These codes seem concerned, first and foremost, with doctors' views of themselves and how they can keep their professional standing high; they are little concerned with the views of patients. They contributed to a 'dehiscence' within medical practice, which has been of importance in separating doctors from patients, at least in the person-to-person mode I described earlier: I describe variants of this. They amount to profound structural failures of medicine in that they improve the

efficiency of medicine but at the cost of separating our professional duties from our moral obligations.

3.1.1 The Reformation

> ***XIV. Of Works of Supererogation.***
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> *Voluntary Works besides, over and above, God's Commandments, which they call Works of Supererogation, cannot be taught without arrogancy and impiety: for by them men do declare, that they do not only render unto God as much as they are bound to do, but that they do more for his sake, than of bounden duty is required: whereas Christ saith plainly, When ye have done all that are commanded to you, say, We are unprofitable servants.*[185]

As a young man attending church I sometimes looked at the back of the Prayer Book and glanced at the 39 Articles of the Church of England. When I first came across Article 14 I had no idea of what supererogation was about, though the early English prose carried a critical tone. The history of the Reformation helps us to understand why this ancient concept came under such fierce attack.

The chief opposition from the Reformers, who were themselves Catholic, was caused by the corruption of the church, most notably shown in the sale and purchase of indulgences, and Luther reserved some of his strongest invective against this practice.[186] The Reformers were not against good works per se, but were against the belief that good works by themselves earned us salvation; they held that only the grace of God could bring this about. There was the further danger that our attendant feelings of pride and condescension could in fact separate us from the love of God.[187] According to Heyd's classification of supererogation, we could say that the Reformers were clearly anti-supererogationist; that is to say, all the good that we might do for others could not be divided into obligatory and optional requirements. For both

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185 'ARTICLES AGREED UPON BY THE ARCHBISHOPS AND BISHOPS OF BOTH PROVINCES, AND THE WHOLE CLERGY, IN THE CONVOCATION IN THE YEAR 1562, *for the Avoiding of Diversities of Opinions, and for the Establishing of Consent touching True Religion'*

186 Indeed the large market in indulgences seems ridiculous to us now. David M. Whitford (ed) *Martin Luther in Context,* (Cambridge: Cambridge University Press, 2018) for examples of this.

187 Writing of the love of praise, St Augustine points out that 'for, though that glory be not a luxurious woman, it is nevertheless *puffed up, and has much vanity in it'.* Paul Ramsey, *Basic Christian Ethics,* 204.

Luther and Calvin there was to be no treasury of merit; no human act, even self-sacrifice, could guarantee salvation. It was through faith alone ('sola fide') that one could access God, and any good works were the consequences of faith. Grace could not be earned, only bestowed by God.[188]

I have not been able to find a direct causal link between the fall of supererogation in the Protestant church and the growth of medical practice, but we can illustrate its fall in the life and work of Paracelsus (1493-1542), described by Roy Porter.[189] He was a doctor of wide influence who epitomises the movement away from Catholic tradition, along with the predominance of Aristotle in philosophy and Galen in medicine. Appointed the town's physician and professor in Basel, he chose not to speak Latin, preferring his native tongue. He disdained academic dress and wore a leather apron indicating his interest in chemistry, a subject then bound up with alchemy, astrology and mystical spiritual forces.

Paracelsus did not look to the Catholic church for guidance on these matters; as a radical Protestant he was making the medical world anew for himself and his followers. As Porter writes, 'Personal experience was what counted - "he who would explore nature must tread her books with his feet"'. [190] What we fail to find in Paracelsus is any sense of the precepts and counsels which were described in the work of Aquinas; indeed in this respect, Joachim Hruschka has traced the metamorphosis of supererogation from one based on counsels in Aquinas to one which simply amounts to 'meritorious duty' by the time of the Reformation.[191]

We can see that new medical ideas were emanating from Protestant countries, with their attendant overthrow, not just of the Catholic church and the authority of the Pope, but of a way of thinking about our relationship with God. In fact by the seventeenth century the concept of supererogation, though still retaining some sense

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188 Hauerwas points out that Christ heals those who turn to him but he does not seek out the sick in order to demonstrate his powers. Stanley Hauerwas, 'Jesus and the Social Embodiment of the Peaceable Kingdom', in *The Hauerwas Reader* (Durham and London: Duke University Press, 2005), 124.

189 Roy Porter, *The Greatest Benefit to Mankind, A Medical History of Humanity from Antiquity to the Present* (London: Harper Collins, 1997), 201-211.

190 Porter, 204.

191 Joachim Hruschka, 'Supererogation and Meritorious Duties', *Jahrbuch für Recht und Ethik,* 6 (1998) 93-110, p.105.

of going beyond what is required, had largely come to mean little more than excessive or superfluous.[192]

3.1.2 Descartes and the Body as Mechanism

How was supererogation lost sight of in medicine? We need to look at the philosophy of science underpinning this change. A feature of the movement from the mediaeval to the modern medical world was the sense of disengagement from the patient in order to concentrate upon the body of the patient. This was a movement away from the spiritual towards the material, and by examining the body in minute detail doctors took themselves beyond the reach of the Church. Jonathan Sawday describes the 'culture of dissection' which led to a new 'philosophy of understanding', and he writes of 'the *discovery* of the Vesalian body' leading towards 'the later *invention* of the Harveian or Cartesian body'.[193]

The historical process of disengagement from the humanity of the patient is described by Charles Taylor, citing Descartes as the origin of this process in philosophy.[194] In fact we could now describe Descartes as a prominent early philosopher of medicine.[195] Taylor claims that Descartes, inspired by the mechanistic observations of Galileo, 'was moved by the ideal of disengaged rational control'.[196] Taylor relates this to the stripping away of Aristotelian belief in the teleological purpose of nature, so that fact and value, until then closely intertwined, came to be separated. Under the Enlightenment the ideal of rationality came to have undisputed hegemony; it seemed as if the world was simply waiting for us to impose our agency upon it in an unprejudiced way. As Taylor puts it,

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192 'Flay not thy Servant for a broken Glass, nor pound him in a Mortar who offendeth thee; supererogate not in the worse sense, and overdo not the necessities of evil; humour not the injustice of Revenge'. Sir Thomas Browne, *Religio Medici and other writings* (London: Dent, 1965), 272.

193 Jonathan Sawday, *The Body Emblazoned: Dissection and the Human Body in Renaissance Culture* (London and New York: Routledge, 1995)

194 Charles Taylor, 'Justice After Virtue' in *After MacIntyre, Critical Perspectives on the Work of Alasdair MacIntyre,* eds. John Horton and Susan Mendus (Cambridge: Polity Press,1994).

195 Vincent Aucante, *La Philosophie Médicale de Descartes* (Paris: Presses Universitaires de France, 2006). with a review article by Gideon Manning, 'Out on a Limb, The Place of Medicine in Descartes' Philosophy', *Early Science and Medicine,* 12 (2007) 214-222.

196 Taylor, 20.

> The neutral world of nature waiting to have purposes imprinted on it is the correlate of the disengaged subject. Neutrality is the property he *ought* to perceive in the world, if he is to realize his potentiality as the free agent of dignity and rational control.[197]

An illustration of disengagement can be found in the neurological clinic; the consultant's deft examination of the cranial nerves elicits small but precise movements of the eyes, the face, the tongue, the head, responses which reveal much to the neurologist while leaving the patient barely aware of what is going on. On ward rounds in teaching hospitals the display achieves a rapid-fire impression of mastery and control. The doctor is single-minded while the patient is disengaged from the process; the knee jerks for example are to be elicited in as 'clean' a manner as possible, without the patient's intervention. The patient is to remain in a state of acquiescence.

This display of mastery contributes to the air of 'dignity and rational control', but this neutrality comes at a price. The danger is when that control passes over into the conversational part of the consultation with consequent distancing from the patient; the doctor then, instead of simply imparting the diagnosis, *imprints* his view of the matter on the patient. Such views illustrate how the so-called 'medical body' came to be the possession of doctors, and the prevalence of this attitude has been further identified by Byron Good in his recent studies of medical anthropology.[198]

3.1.3 Dignity and Rational Control

Let us look more critically at dignity. We began this thesis with a look at Hogarth's murals in St Bartholomew's Hospital; now let us look at a painting which epitomises dignity and rational control. In the Mauritshuis in The Hague is a well-known painting by Rembrandt, *The Anatomy Lesson of Dr Tulp,* from 1632. Dr Tulp is demonstrating to a group of onlookers, not students but older men, the anatomy of the arm. This painting has been subject to a large body of multidisciplinary, scholarly

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197 Taylor, 20.

198 Byron Good, *Medicine, Rationality and Experience* (Cambridge: Cambridge University Press, 1994). The dust jacket shows Rembrandt's painting of Dr Tulp's anatomy.

research and long-standing interest in it continues in the humanities.[199] The cadaver would have been obtained from the hangman at a time when public dissection was part of judicial punishment. The face of the cadaver is pallid and barely delineated, but the forearm, dissected to display the muscles, is painted in detailed colour. Dr Tulp holds up the muscles with an instrument held in his right hand and indicates with his left hand the movement which the muscles would have accomplished in life. He is finely dressed in black satin suit and lace collar, with a neatly trimmed beard.

The onlookers in *The Anatomy Lesson* were from the Amsterdam Guild of Surgeons, at the height of their careers, and they gaze intently on the dissected arm or on the hands of Dr Tulp. The study of the painting has been appropriated by various academic disciplines; as a recent scholar of cinematography has noted, the onlookers are not looking at *the dead man,* and furthermore, the naked body, once dissected, is no longer visible: we see only its parts.[200] We might say that dissection deprives him of his personhood; he becomes a mere 'clinical body' in the words of Foucault. Taken collectively, the spectators embody a confident focus on the matter before them, with no wistful inattention or wan thoughts of their own mortality. This was no *vanitas* painting, on the contrary it celebrates professional mastery and dominance both of the subject of the dissection, (a criminal named Aris Kindt), and also of the profession of medicine. The onlookers' stance is one of dignity, and they are portrayed pursuing a rational inquiry into the nature of the body. This early masterpiece of Rembradt is a far cry from his painting of The Good Samaritan. As stated in Chapter 1, the defecating dog in the centre of the etching from 1633 indicates the degrading associations of supererogatory actions, chiefly bodily contact and contamination, as with the inhalation of sputum by the Postman's Park doctors. One cannot imagine Dr Tulp or his companions exposing themselves, without adequate safeguards, to the blood and sweat of their patients. It is thought that Dr Tulp would not have done the

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[199] William S. Heckscher, *Rembrandt's Anatomy of Dr Tulp*: *An Iconological Study* (New York: New York University Press, 1958); William Schupbach, *The Paradox of Rembrandt's 'Anatomy of Dr Tulp'* (London: Wellcome Institute for the History of Medicine, 1982) are standard works in this area.

[200] Janine Marchessault, *An Erotics of Space: The Cinematic Apparatus in the Aura of Science,* https://public.journals.yorku.ca/index.php/public/article/view/29788 [accessed 2 August 2022].
I can testify to this 'disappearance' of the body from my experience as a medical student in the anatomy room. One overlooked the whole body by delving into its 'parts'.

dissection himself; that would have been done by an assistant not thought worthy of inclusion in the painting.[201]

3.1.4 Neutrality towards Suffering

Dr Tulp and his colleagues look the picture of prosperity, showing the self-satisfaction of a profession on the rise. Kenneth Clark points out that anatomical dissections in the Netherlands took place once a year and 'many early anatomy theatres were set up in abandoned chapels'.[202] This indicates the change from a society dominated by the Church in mediaeval times to the early flowering of a more secular and bourgeois class in the seventeenth century. One aspect of professional life was the idea of a lifetime of work, leading to both expertise and personal advancement; to bring to fruition the life represented by Dr Tulp would have required a long devotion to the craft and learning of medical practice.[203] That in turn would have required a measured approach to the routines of practice, with hard work undertaken and due reward expected in return, but with no opportunity for supererogation. Work and worry had to be made to fit the day, otherwise exhaustion would have resulted before fruition could come about. One cannot help but see the body of Aris Kindt as a means to an end for the doctors gathered around him. Their interest began and ended with the exploration of his anatomy. Put starkly, his life, his crime, his trial and his execution were of no interest to them, except as his misadventures supplied a much needed corpse. He lies there, exposed and dissected, for their professional ends; *his* head is mostly receding into shadow, *their* heads crane forward into the light and are luminous in their bloom. Their craving for knowledge is shown in their preoccupation with the parts instead of the whole person.

The painting unwittingly stands for an aspect of medical life which we might not want to look at too closely, that the efficiency of doctors depends on their not taking patients' suffering too much to heart: *their* suffering must not strike too close. This is

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201 The painting still has a bravura function. If not a *vanitas* painting, then it might now be serving as a *superbia* painting, encouraging generations of doctors to preen themselves on their anatomical knowledge in identifying the dissected muscles.

202 Kenneth Clark, *Rembrandt and the Italian Renaissance* (London: John Murray, 1966), 95.

203 'The Good of man is the active exercise of his soul's faculties in conformity with excellence or virtue . . . Moreover this activity must occupy a complete lifetime, for one swallow does not make spring . . .' Aristotle, *Nichomachean Ethics,* bk 1, 1098a 16-20.

made up of three aspects: firstly, we are unable to feel the pain of others, as described by Hauerwas;[204] secondly, the simple fact of habituation which has a desensitising effect;[205] and thirdly, an habitual pushing away of the patient in order to protect doctors' sensibilities. This results in a well-meaning, but distancing, attention to the relief of pain with speed and diligence while skimming over the suffering in haste. This is what I mean by *disengagement*. In the spirit of Bernard Williams in Chapter 2, patients want a doctor to be fully engaged, to have a sense of why the subject of *this* consultation is important to *this* patient at *this* time.

By way of illustration of medical disengagement, though at a rather juvenile level, I remember the first term of anatomy at medical school; after some weeks the time came for the leg to be dislocated at the hip so that dissection of the groin could take place. The twisting of the leg caused the cadaver to turn on the table, and the unexpected movement led us all to call out in nervous laughter. The senior lecturer turned round and angrily said, 'Have more respect for the dead!'. It was a chastening reminder that bodies are given up for the teaching of students and that the donation of the body during life was an act of generosity. Medical students begin their studies on the basis of an act of supererogation by patients; thus the dead give to the living. I see in hindsight that our awkwardness before the cadaver showed that we had not learned how to detach ourselves from the former living person; we had not yet learned to see the cadaver as a 'medical body'.

I do not think it an exaggeration to say that Dr Tulp's anatomy lesson can be taken as a visual representation of Descartes' philosophy; indeed knowledge of Rembrandt enriches our understanding of Descartes, and vice versa.[206] The doctors are entirely focussed on the theatrical performance before them, manifesting the disengaged stance which is the hallmark of Descartes. Furthermore that stance represents a

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[204] 'When we are in pain we want to be helped. But it is exactly at this point that one of the strangest aspects of our being in pain occurs: namely, it is impossible for us to experience one another's pain.' Stanley Hauerwas, 'Salvation and Health' in *The Hauerwas Reader,* eds. John Berkman and Michael Cartwright (Durham and London: Duke University Press, 2001), 549.

[205] 'One who has been witness to a dozen dissections, and as many amputations, sees, ever after, all operations of this kind with great indifference, and often with perfect insensibility'. Smith, *TMS,* 36-37.

[206] J. Leonore Wright, 'Reading Rembrandt: The influence of Cartesian dualism in Dutch art', *History of European Ideas,* 33 (Sept 07), 275-291.

divorce of sympathy from the knowledge that was to be gained from dissection.[207] Not only was the body seen as a mechanism, but the passions associated with the body were relegated to inferior status behind rational understanding.[208]

It is that hegemony of reason which leads to the professional stance, resulting in a discounting of the patient's feelings and a non-recognition of the doctors' feelings towards the patient. This is the origin of Dr Tulp's professional dignity; it accords with Descartes' notion of 'generosity', a term which then 'designated the aristocratic virtue one displays when one has a lively sense of one's own worth and rank and the demands it puts on one'.[209] This better equates with the connotations of *virtu* rather than the *virtues* of Aristotle; something refined, discriminating, superior to the commonplace. Dignity thus carries a double meaning; a rising above our own base natures, and a sense of superiority over others. Such dignity has a benefit for doctors; it allows them to keep their anxiety under control when things go wrong. That is an aspect of the demands put on doctors who uphold their dignity, discounting their own distress when help might reasonably be sought: dignity requires a blunting of responses to the suffering of others. With this in mind we can understand why empathy was a long time in coming to light, only to be 'discovered' in the late nineteenth century.[210] Its recent acknowledgement in medical life has been a problematic one for doctors; they now feel obliged to pay service to the concept while wishing, for reasons of efficiency, to give it a wide berth lest it disable their rational assessments. After all, an empathic response, sincerely felt in full measure, leads us to suffer *equally* alongside the patient.

If we look closely at Rembrandt's works then we will see that his group portraits tell only half the story; indeed his greatest works show a sensitivity to the pathos of life

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[207] Descartes' *malin genie* is a device for elucidating truth but yet represents a disengagement of philosophy from the body, relegating it to a mechanism which can be mastered by anatomical exploration. Ingenious automata reached their heyday in Europe in the seventeenth and eighteenth centuries.

[208] The physician and philosopher Julien Offray de La Mettrie (1709-1751) found that mental processes had a physiological basis. His book, *L'Homme Machine* (1747), expounds the mechanical and the material. Adam Vartanian, *La Mettrie's L'Homme Machine* (Princeton, NJ: Princeton University Press, 2015)

[209] Taylor, 19.

[210] Primarily in Germany. Robert Fischer (1847-1933) introduced the term *Einfühlung*. Hermann Lotze (1817-1881) Theodore Lipps (1851-1914) were active in this area. *Einfühlung* was translated into 'empathy' by Edward Tichener in 1909.

which is deeply moving. His series of self-portraits are well known for showing an unvarnished acceptance of the sadness and limitation of growing older.[211] Most tantalizingly, if a later *Anatomy* by Rembrandt had survived intact then we might have been granted a view of doctors combining both qualities of worldly success and empathic pathos.[212] Only a fragment of *The Anatomy Lesson of Dr Jan Deyman* (1656) survives after a fire in 1823, but it shows an assistant, serious and paying attention to the corpse, holding the detached cranium while the doctor examines the brain. The face of the cadaver retains its individuality, while the face of the anatomist has been lost in the fire. The damage allows us to concentrate on the cadaver and the assistant, a change of perspective; this is an example of a process described by Taylor, away from 'the goods of citizen dignity and fame for one's great deeds'.[213] Doctors might pursue such goods with zeal, but at the cost of forgetting the face of the patient before them.

Both of Rembrandt's anatomy paintings illustrate the medical condition, but from opposing points of view. Dr Tulp represents a 'sanitised', doctor-led view of medicine, while Dr Deyman's Anatomy Lesson appears to treat the cadaver with more respect, acknowledging its humanity. The painting of Dr Tulp shows an ambitious, dignified doctor rising above the intractable messiness of life, but true dignity in medicine encompasses all aspects of human life, including the corruption of the corpse. Dissection is both smelly and messy, especially when the abdomen is opened, yet 'the unsettling sacramental' quality of Dr Deyman's Anatomy Lesson has been noted by Simon Schama in his study of Rembrandt.[214] In busy practice it is easy to forget the supplicatory quality of patients coming forward for our imperfect

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211 While Dr Tulp displays the quality of dignity as representing 'the dignity of merit' and perhaps too 'the dignity of identity', the self-portraits display *Menschenwürde,* that dignity which is universal and inalienable, despite the growing worries about money which troubled Rembrandt in later life. L. Nordenfelt, 'The Varieties of Dignity' *Health Care Analysis,* 2004, 12(2), pps. 69-82.

212 The pose of the body in *The Anatomy Lesson of Dr Jan Deyman* in the Rijksmuseum is derived from Mantegna's *Dead Christ*. Kenneth Clark says that 'Involuntarily we look for the stigmata on the hands and feet'. Clark, 95.

213 Taylor, 32.

214 'The exposure of the brain of the *subiectum anatomicum* suggests that thought, even more than dexterity, the sapient mark of humanity, was both a mass of viscous, blood-filled matter and a supreme marvel of God's work'. Simon Schama, *Rembrandt's Eyes* (London: Allen Lane, Penguin, 1999), 604.

attentions.[215] That quality became obscured by the professionalization of medicine, as described next.

3.1.5 The Rise of Professional Standards

The rise of the professions in the eighteenth and nineteenth centuries was associated with the development of medical ethics. This flourished from the later eighteenth century until the second half of the twentieth century, giving way in turn way to bioethics. The rise of professional ethics has pushed morality to the wings. In this section I show how professionalization, along with medical ethics, led to a narrowing of attitudes and behaviours by doctors with a growing sense of their self-governance.

3.1.6 Professional Behaviour and Moral Sense

In this section I am looking at the professional changes which went alongside philosophical changes, from a world of morality to a world of circumscribed rules based on ethical codes. I describe a stiffening of responses to patients as doctors became beguiled by new ideas. Much work has been done on the rise of the professions, along with the distinctive rise of medical etiquette and ethics,[216] and a lengthy chronology of changes in regulations affecting the profession is available.[217] Noteworthy for our purposes is the rise and fall of natural law,[218] of great concern in seventeenth century philosophy, because it came to be regarded as independent of divine law. Thomas Hobbes, with his contractual approach to law, found no place for supererogation, but Grotius, according to recent scholarship, did leave space for the concept.[219] Johanna Geyer-Kordesch points out that 'the theoretical basis for

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215 The utter helplessness of patients who are severely injured but still conscious is particularly moving. The author remembers, as a medical student, attending a patient whose arm had been badly crushed in a fair-ground accident. Amputation seemed likely, but the arm was saved. I held the flailing arm steady during the three hours of surgery. The supplicatory quality was evident on his face as the general anaesthetic was administered.

216 Andreas-Holger Maehle, Johanna Geyer-Kordesch, (eds) *Historical and Philosophical Perspectives on Biomedical Ethics, From Paternalism to Autonomy?* (London: Routledge, 2002).

217 Michael D. Warren, *A Chronology of State Medicine, Public Health, Welfare and Related Services in Britain, 1066-1999* (London: Faculty of Public Health Medicine of the Royal College of Physicians the United Kingdom, 2000).

218 John Finnis, *Natural Law and Natural Rights* (Oxford: Oxford University Press, 2011).

219 Johan Olsthoorn, 'Grotius on Natural Law and Supererogation', *Journal of the History of Philosophy* 57 (2019), 443-469.

medicine in the later seventeenth and eighteenth centuries was intellectual and a product of the learned culture of Protestantism', with morality becoming divided into '*spiritual values* as the domain of religion and *ethical values* as the foundation of civic life'.[220] A cleft appeared here with morality becoming equated with the residual influence of the Catholic church in Northern Europe, while the thrusting professions looked to ethics as their anchor and guide. Various aspects emerge from this historical change:

1. Standards of professional behaviour came increasingly from within the profession, led by doctors and not by the church. These were such as to be comfortable for the doctors concerned, and this led to what Geyer-Kordesch calls 'redefinitions of normative values'. [221]

2. Prudent behaviour was expected of doctors; this was more concerned with the regulation of behaviour than the inner workings of a doctor's mind. Prudence belongs to the *forum externum*, while the doubts and hesitations of a doctor's practice relate to the *forum internum*, that reflective area of mind concerned not with prudence, but with issues of *iustum et honestum*.[222]

3. Prudent behaviour was indicated by decorum; that in turn was concerned with the whole of a person in terms of the Enlightenment, not just with skill but also with the doctor's mode of presentation. Doctors were expected to show fitness for practice in a *tout ensemble* of skill, manners and dress. [223]

4. Self-governance of a doctor's emotions would be enjoined to prudent behaviour. Geyer-Kordesch focuses on the work of Christian Thomasius, a German influential in Prussia; his emphasis was on moral behaviour, and he aimed 'to create a better moral order within civic society, outside of state sanction, namely to sketch in that

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220 Johanna Geyer-Kordesch, 'Natural Law and Medical Ethics' in *The Codification of Medical Morality Volune One: Medical Ethics and Etiquette in the Eighteenth Century,* ed. by Robert Baker, Dorothy Porter and Roy Porter (Dordrech: Kluwer Academic Publishers, 1993), 125.

221 Geyer-Kordesch, 126.

222 Geyer-Kordesch, 127.

223 Old Master paintings show prudence personified as carrying a mirror, indicating the self-reflection required of us by this virtue.

undefined area in which we normally acted'.[224] This was that large aspect of life which was neither prohibited nor prescribed, and this was a rich mine of observations which led to the formation of professional codes.

I illustrate this with reference to the literature of the period, including novels, history, and philosophy. As G. S. Rousseau pointed out in an early essay, medicine is often described in literature, and indeed might be the central theme of a novel,[225] yet literature does not discernibly influence medicine. Forty years after Rousseau's essay I am making this link between medicine and literature in an attempt to redress the balance, for I believe that literature did influence my practice, at least by indicating some of the attitudinal mistakes to avoid. I hope that other doctors can also learn from these lessons and put them into practice. The study of literature points to the important lessons that doctors can learn from wide reading, becoming more reflective as a result. If doctors concentrate exclusively on professional skill then they become unbalanced; they neglect the third variety of goodness described by G. H. von Wright which relates to the 'trait of character' of the whole person.[226]

The medical humanities, especially medical anthropology, have helped to show the complex interactions within the medical market. The rise of the professions led to the exclusion of certain behaviours as outside the desirable and acceptable mode for doctors. Just as Geyer-Kordesch, in her study of the medical profession in Prussia, points out that, 'the elite of the professions used the background of natural law theory to devise their own moral sensibilities',[227] so we can see a parallel process in the novels of Jane Austen where the reader is invited to develop a moral sensibility which stems from the observation of others, and how their behaviour reveals character in a commendatory or critical way. Geyer-Kordesch states that 'Morality, in this enlightened sense, means right action based on personal insight and adequate action'.[228] We can see this personal insight in Jane Austen's characters, and indeed Jane Austen herself. Women relied on the development of insight into the characters of others, especially of their perception of men at a time when most women lacked

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224 Geyer-Kordesch, 126-7.
225 G. S. Rousseau, 'Literature and Medicine: The State of the Field', *Isis,* 72 (1981), 406-424.
226 Von Wright, 6-7. The two other forms of goodness are the Instrumental and the Technical.
227 Geyer-Kordesch, 126.
228 Geyer-Kordesch, 128.

financial independence. Similarly, for contemporaneous doctors right action was less bound by the constraints of 'a system of morality' but by personal evaluation of 'a secularized principle: civic good'.[229]

The illustration of the rise of the profession, using novels as illustration, throws light on how doctors' duties came to be defined, and thus, by exclusion, of what was thought to be outside such duties. I also discern the eighteenth century tone in letters and philosophical texts of that period too; that tone has been called 'the easy graceful agreeability of the 18th century',[230] whose characteristic qualities are urbane and mannerly, far removed from the earnestness of practitioners who are likely to be drawn to supererogation.

This tone is associated with the prose style of Jane Austen. It is well known that Jane Austen was not sentimental,[231] but she could be described as a 'sentimentalist', where that term refers to the philosophy of Francis Hutcheson and David Hume, inviting us to feel our way to what is right and not simply relying on rationality alone. This was an expression of 'moral sense' where we are expected to feel as we ought, and where moral sense shades into worldly good sense. Moral sense was based on 'disinterested reflection' of actions.[232] In this light, I think we can see that disinterested reflection seeks to remove personal inclinations from the appraisal of moral actions; we are here looking for worldly judgement with which other sensible people might agree. Moral sense, according to Adam Smith, acts 'to superintend all our senses, passions, and appetites, and to judge how far each of them was either to be indulged or restrained'.[233] There is a sense of restraint of impulse, superintending the fanciful and excessive, and again this sounds like a limiting effect on supererogation. A close reading of Adam Smith's, *The Theory of Moral Sentiments,* illustrates this tone of good judgement based on good sense, with a fine discrimination of what is required from us in how we *ought* to feel. In fact Adam Smith's writing has been compared to

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229 Geyer-Kordesch, 128.
230 David Cecil, *Library Looking Glass: A Personal Anthology* (London: Constable, 1975), 68-72
231 'How horrible it is to have so many peoples killed! - And what a blessing that one cares for none of them' *Jane Austen's Letters* ed. by R.W. Chapman (Oxford: Oxford University Press, 1952), 286.
232 Mary Warnock, 'Moral Sense', in *The Oxford Companion to Philosophy,* ed. by Ted Honderich (Oxford: Oxford University Press, 2005), 632.
233 Adam Smith, *TMS*, 191.

that of a novelist in that readers are left to judge the characters for themselves.[234] Smith writes with finesse, and we can see him taking pride in his discrimination, as with his exchange of letters with David Hume on the nature of sympathy.[235] Such finesse, I believe, is desirable for doctors to acquire; it is a palliative to patients as it reveals how the doctor is not just intent on reaching a diagnosis but is fully engaged with the patient's plight. This could be seen as supererogation because it requires imaginative work, done for the sake of the patient, yet does not require much expenditure of time once the habit has been acquired. What this leads to is the idea of supererogation revealing how to relieve patients' suffering in an imaginative and creative way, yet behaving outwardly within the confines of eighteenth century *mores*.

What both medical professionalization and literature demonstrate is an erection of boundaries within society. As Eliot Freidson showed in his foundational study of the sociology of medicine, a feature of doctors' professionalization was their claim to autonomy; they became their own masters and it was the profession which judged on matters of competence.[236] Boundaries both contain and exclude, so doctors began to exclude unlicensed practitioners from their estate, just as they confined themselves within a range of emotions and behaviours, the better to preserve decorum and prestige. Doctors sought an all-encompassing control over illness and wayward patients, and this was desirable in an age of ineffective treatments when a doctor's prestige depended more on the mode of presentation and skill with which the consultation was handled.[237] Indeed in this respect, it has been pointed out by Neil Vickers that in Jane Austen's *Emma* there is little attempt made to diagnose the illnesses of the characters; it was wise then and now for doctors to reserve judgement

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234 'Somewhat like a novelist, he presents a wide variety of moral characters who often judge each other but who rarely are judged directly by the author, except in his capacity as a representative of "common opinion". For the rest, judgement is up to the reader.' Introduction to Adam Smith, *TMS* ed. by Knud Haakonssen (Cambridge: Cambridge University Press, 2009), viii.

235 Hume accused Smith of confusing the nature of sympathy, as it seems that Smith thought that all sympathy was agreeable: 'It is always thought a difficult Problem to account for the Pleasure, received from the Tears and Grief and Sympathy of Tragedy; which woud [*sic*] not be the Case, if all Sympathy was agreeable. An Hospital would be a more entertaining Place than a Ball.' Adam Smith, *TMS,* 56.

236 Eliot Freidson, *Profession of Medicine A Study of the Sociology of Applied Knowledge* (New York: Harper and Row, 1970).

237 'Duty of course is deeply important, but superadded to it there must be "delicacy".' Tony Tanner, 'Introduction' in Jane Austen, *Mansfield Park* (London, Penguin: 1973), 31.

on those chronic illnesses which serve to 'sustain a lifestyle': in other words, we should be cautious about dismantling a patient's defences. [238]

The struggle for doctors to be recognised as gentlemen has been studied in detail in the city of York where the late eighteenth century 'Doctors' Club', a sociable and convivial meeting of medical men and other gentlemen, gave way to the 'Medical Society' in the first half of the nineteenth century. The 'Medical Society' was for doctors only and focussed on professional matters and education; it was part of the sequestration of a respectable space for themselves against reforms in wider society. As the author of the study writes, 'Manners had given way to "ethics", and the civic space of the tavern-based club had given way to the medical space of the Dispensary-based society'.[239] This change from doctors' club to medical society is paralleled by a change in clinical practice: there was movement away from decorum and manners towards more easily recognised modes of professionalized behaviour.

As Geyer-Kordesch remarks, there was to be much 'dancing in the middle ground'.[240] I suggest that doctors set about keeping themselves in the safe space beyond the criticism of patients, and indeed beyond those societal forces which were in opposition to them. How would this have affected doctor's view of supererogation if they were intent on dancing in the middle ground? Supererogation from doctors would thus have been going too far; it would have been indecorous, frowned upon as much as the 'enthusiasm' disdainfully attributed to Methodist preachers by the Anglican clergy; indeed John and Charles Wesley were mockingly called 'the Supererogation Men' by their contemporaries at Oxford. That seems to keep doctors firmly within the precepts of their profession, and not straying beyond their estate into the counsels of an earlier age.

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238 Neil Vickers, 'Medical anthropology in Jane Austen's *Emma',* in *Clinical Medicine,* 8 (2008), 224. Emma's father, Mr Woodhouse, comes in for especial study here; a valetudinarian who controls his daughter even after her marriage. Sometimes only an illness, carefully sustained, makes life bearable for those afflicted.

239 Michael Brown, 'From the Doctors' Club to the Medical Society: Medicine, Gentility and Social Space in York, 1780-1840, in *Eighteenth-Century York: Culture, Space and Society,* ed. by Mark Hallett and Jane Rendall. (York: University of York, Borthwick Institute of Historical Research, 2003), 68.

240 Geyer-Kordesch, 129.

In summary of this section so far, I claim that supererogation was lost sight of because decorum required doctors to behave in predictable and acceptable ways. Decorum was the sign of a gentleman.

Cure is not always desired; care always is. This delicacy and reticence is about knowing how far to go, how much a patient can be led. It is far removed from the world of the Good Samaritan's arrival at the inn in the Rembrandt etching described in Chapter 1, where supererogation depended on getting your hands dirty and suffering alongside the victim. One such way for doctors to control their interactions with patients was to claim medical vocabulary as their own. The medical historian Mary Bissell describes how in the early modern period the patient's presenting complaint, at one time told verbatim by the doctor from the patient's account, became transformed and translated into medical vocabulary, and indeed this way of doing things is still with us.[241] Bissell describes this as the 'disappearance of the patient's narrative', but it was not just that the patient's story was lost; we can make the bigger claim that the onus fell increasingly on patients; *they* were expected to defer to doctors and to behave in medically approved ways. In moving the consultation from the home to the clinic doctors came to commandeer the space in which they met. I interpret this change in practice as reducing the doctor's vulnerability to the patient, and this further pushed away the notion of supererogation from having any place in ordinary medical behaviour.

3.1.7 Dr Burton and Dr Slop

The professionalization of medicine, with its attendant clamour for control of the medical estate, is illustrated in the character of Dr John Burton (1710-1771) who practised obstetrics in York. I now wish to look at him in some detail. He was a larger than life character who was briefly imprisoned as a Jacobin supporter at the time of the 1745 rising. He is now recognised as the medical practitioner who gave Laurence Sterne the inspiration for the character of Dr Slop in his novel, *Tristram*

[241] Mary E. Bissell, 'The disappearance of the patient's narrative' in *British Medicine in an Age of Reform,* ed. by Roger French and Andrew Wear (London: Routledge,1991), 91-109.

Shandy (1759-1767).[242] The contrast between what we know of Dr Burton and how he is portrayed as Dr Slop tells us something important, and perhaps we can see in Dr Slop a behind-the-mask view of those things which doctors could not perceive in themselves but which were apparent to novelists.

Less well known is that Burton wrote a book on obstetrics, *An Essay towards a New System of Midwifery,* published in 1751.[243] It is largely made up of case histories of women in York with detailed accounts of their difficult labours and what Burton was able to do for them. Details of child birth in that period are well known, and the reader is not spared the suffering of the patients. The gravity of the women's situation is striking, along with the extreme danger to their unborn children, but what is also notable is that the women are barely described. We know nothing of *their* feelings, but Burton's feelings are obvious, directed against those who meddled in what he believed should have been his work from the start.[244] He is self-righteous and intolerant. While he expresses a vicarious indignation on behalf of his patients, nevertheless the tone is one of disregard for the suffering of the patient while the business of the obstetric work is attended to. If this one author can be cited as an example of what I described earlier, it is evident that feelings towards the patient have been confined to something workman-like and devoid of empathy. There was a job to be done and Burton was the man to do it.

Burton's purpose in writing the book seems to fall into the realm of reputation building; it is addressed to members of the profession, and the compilation of case histories relegates the patients to the building blocks of his reputational fortress. His robust handling of patients is more akin to the tone of the doctor-author Tobias Smollett rather than the delicacy of Jane Austen.[245] He could be cited as an example of what professionalization was trying to suppress: Geyer-Kordesch describes, 'the systemised ethics whose characteristics [...] included dogmatism, absolutism,

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242 Sterne wrote the novel while holding the living at Coxwold in the North Riding.

243 John Burton, *An essay Towards a Complete New System of Midwifery* (London: 1751) described in P.M. Dunn, 'Dr John Burton (1710-1770) of York and his obstetric treatise', *Archives of Diseases in Childhood Fetal and Neonatal Edition,* 84 (2001), F74-F76.

244 An early example of the change from seeing the patient as a person to seeing the patient as an object, described in N. D. Jewson, 'The Disappearance of the Sick-Man from Medical Cosmology, 1770-1870' , *International Journal of Epidemiology,* 38 (2009), 622-633.

245 Smollett's picaresque novel, *The Adventures of Roderick Random,* reflects his experience as a surgeon's mate on a Royal Naval vessel in 1741.

inevitability, and infallibility'. [246] He was a die-hard practitioner, non-reflective and self-righteous. We picture him blundering his way to do good for his patients, with his newly designed forceps, scornful of midwives and unlicensed practitioners who had preceded him. Something of the character of Burton is said to be found in the burlesque of Dr Slop in *Tristram Shandy* where Dr Slop demonstrates the use of his forceps, using Uncle Toby's clenched fists in place of the baby's head, crushing his knuckles into jelly. The tone is worldly and insensitive, and I suggest this shows that Sterne perceived Dr Burton as more concerned with his forceps than the well-being of the patient.[247]

Burton's book also contains an account of the conflict he had with Dr Smellie, the celebrated London obstetrician. They had both designed obstetric forceps, and each man was keen to promote his own invention. We might nowadays expect an evidence-based account, a disagreement between equals; in fact, judging from the tone, there is a sense of Smellie's condescension, himself the consummate London doctor, towards a provincial fellow. That maddened Burton who was quick-tempered and who did not fail to express his resentment. In fact, although Dr Slop has a comic quality, in reality the doctors of the eighteenth century displayed an aggressive posturing towards each other. Robert Baker, on describing the disputes of three eighteenth century doctors, as vexatious as Burton, states,

> to an extent almost unimaginable today, their lives were enmired in disputes not only in law courts and correspondence with other professionals, but in letters and pamphlets which they published to defend their personal and professional reputations. In the process they not only air the profession's dirty linen in public, but parade their own absence of standards to modern eyes. [248]

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246 Geyer-Kordesch, 129.

247 His forceps were leather-covered and have not survived. His book is distinguished by the fine engravings by George Stubbs which include views of the foetus within the womb. The engravings evoke the extreme danger of obstructed labour. Basil Taylor, *Stubbs* (London: Phaidon, 1975), 39.

248 Robert Baker, 'Medical Propriety and Impropriety in the English-Speaking World prior to the Formalizations of Medical Ethics', in Robert Baker, Dorothy Porter, Roy Porter eds., *The Codification of Medical Morality: Historical and Philosophical Studies of Western Medical Morality in the Eighteenth and Nineteenth Centuries. Vol. One: Medical Ethics and Etiquette in the Eighteenth Century* (Dordrecht: Springer, 1993), p. 15.

I suggest that patients would not have expected such doctors to behave in a supererogatory fashion and that that the burlesque of Dr Slop points to the vanity of the profession on the rise.

In contrast to the roughness of Dr Slop we have the exquisite side of late eighteenth century manners, though novelists are concerned here, I believe, with a perceived self-importance of doctors which again is out of sympathy with supererogatory inclinations. Sterne also wrote *A Sentimental Journey,* and in the section entitled, *The Pulse*, describes all the feelings of temptation and false posturing which a man might enjoy in letting himself be mistaken for a doctor. As Geyer-Kordesch points out, referring to similar approaches in German literature,

> This sort of attitude tends to rewrite codes and is notoriously difficult to systematize. It does not really fit the definition of ethics as a system of morals. Secularized morals of this sort are character-based, and in this period argued didactically on the grounds of individual reason.'[249]

Once again we find the individual judging his behaviour for himself, not relying upon any distinction between precepts and counsels, for indeed once counsels have fallen out of consideration then so has the concept of supererogation, at least as understood by the mediaeval church.

As the eighteenth century progresses we see a change in professional standards, reflected in the novels of the period, from a robust aggression to a polite exchange of views with many preambles of courtesy. We could say that the binary choice between right and wrong has changed into a complex pattern of hesitation, stepping out, and then *reculer pour mieux sauter.* These attitudes seem inauthentic to us now: both the rough and ready approach and the over-refined politeness are at odds with that quality of protrepsis mentioned earlier where doctors are encouraged to enter deeply and with an appropriate thoughtfulness into the patient's suffering, and to be fully engaged, medically, emotionally, and even philosophically. Medical practice can become very 'thin' without such depth. The aggressive competition between doctors, and the

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249 Geyer-Kordesch, 130.

novelists' portrayal of their self-posturing, all jockeying for professional ranking, is far removed from such deeper explorations.

In this section I have described changes brought about by the professionalization of medicine, with a growing sense of boundaries to delimit and exclude, and underpinned by intense competition between doctors for a share of the medical market. This contrasts with the illustrations of doctors by novelists where the profession came under both satirical and sympathetic regard. I next look at attempts by doctors to consolidate their new professional standing.

3.1.8 Medical Ethics and Thomas Percival

With turbulence in society, and the changing views of doctors by patients, at least as regarded by novelists, there is little wonder at the growth of codes of medical practice. They can be seen as an attempt to regulate doctors, not just in behaviour towards patients and colleagues, but also in ways of thinking about themselves. It is worthwhile examining them closely both in content and in tone. Thomas Percival's 1803 publication is one of the best known: *Medical Ethics, of, a code of Institutes and Precepts adapted to the Professional Company of Physicians and Surgeons.* The dedication is to his son, who was also a doctor:

> It is the characteristic of a wise man to act on determinate principles; and of a good man to be assured that they are conformable to rectitude and virtue. The relations in which a physician stands to his patients, to his brethren, and to the public, are complicated, and multifarious; involving much knowledge of human nature, and extensive moral duties. The student of professional Ethics, therefore, cannot fail to invigorate and enlarge your understanding; whilst the observance of the duties which they enjoin, will soften your manners, expand your affections, and form you to that propriety and dignity of conduct, which are essential to the character of a GENTLEMAN. [250]

What we see in Dr Percival is a movement away from etiquette towards ethics, a much more serious development. Lisbeth Haakonssen demonstrates that we can no

[250] Thomas Percival, *Medical Ethics of, a code of Institutes and Precepts adapted to the professional company of physicians and surgeon* (Manchester: J Johnson, St Paul's Church Yard, and R Bickerstaff, Strand, London,1803), reprint from the Yale University Medical Historical Library. p. viii.

longer see doctors as concerned solely with etiquette; she details the philosophical underpinning of this new focus, which includes the works of Francis Bacon, Thomas Reid and the dissenting tradition.[251] Of note in the above quotation is that firstly, it is not morality, but professional ethics which is to be studied; secondly, manners are to be softened in accordance with societal changes; thirdly, there is a very strong focus on doctors' dignity. We note a hiving off of morality into the religious sphere where a minister of religion is to be called upon:

> The moral and *religious influence* of sickness is so favourable to the best interests of men and of society, that it is justly regarded as an important object in the establishment of every hospital. The *institutions* for promoting it should, therefore, be encouraged by the physicians and surgeons, whenever seasonable opportunities occur [. . .] The character of a physician is usually remote either from superstition or enthusiasm: [252]

Doctors were busy carving out their own professional estate, and were content to let clerics have governance of theirs. The disdain of superstition and enthusiasm suggests a narrowing of what was thought appropriate in speech and deportment, with no straying outside the boundary. If morality was becoming the province of religion, ethics was the province of law:

> This work was originally entitled 'MEDICAL JURISPRUDENCE'; but some friends having objected to the term JURISPRUDENCE, it has been changed to ETHICS. According to the definition of Justinian, however, Jurisprudence may be understood to include moral injunction as well as positive ordinances. *Juris pracepta sunt haec; honeste vivere; alterum non laedere; suum cuique tribuere.* [253]

The Latin quotation is from the *Institutes of Justinian* ('The precepts of the law are these; to live honourably; not to injure another; to give each his due'); this suggests a distinction between precepts which are to be followed and counsels which can be left out of the equation. This points to what can be done within the constraints of the system in which doctors find themselves, rather than looking at the foundations of medical practice itself. *Suum cuique tribuere* is after all, more concerned with

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[251] Lisbeth Haakonssen, *Medicine and Morals in the Enlightenment: John Gregory, Thomas Percival, and Benjamin Rush.* Clio Medica, vol.44, Welcome Institute Series in the History of Medicine (Amsterdam: Editions Rodopi, 1997).

[252] Percival, 11.

[253] Percival, 7.

fairness than with the generosity of reaching out to others in an open-handed way. For doctors influenced by Percival, supererogation came to belong to that space beyond the professional world. There was no interest in straying beyond the estate, for doctors who wished to be seen as professional gentlemen had no respectable business in going recklessly beyond their estate. Duty had become paramount.

3.1.9 Conclusion to Part One

I have outlined changes in the organisation of the medical profession in the eighteenth century, along with reflections on this process as interpreted by novelists' perception of changes in decorum and *mores*. Doctors fought hard to secure a space for themselves, to demarcate boundaries and to be seen as respectable and praiseworthy. Professionalization however led to a rigid separation from their patients, and it also led to an attenuation, if not a deadening, of doctors' feelings towards patients as people who were owed ordinary moral obligations. Sequestered within codes of behaviour, doctors came to see patients not so much as suffering individuals, but as exemplars of embodied disease. Furthermore, doctors came to believe that they could best serve their patients by responding in a disengaged manner, emphasising what could be done scientifically; if science had little to offer then that was hardly the doctor's fault!

In the next part I describe how the process developed in the nineteenth century, and I claim that it was the growing delineation of duties which aggravated this separation. The contractual nature of the relationship came to obscure the humanity of the encounter, with the doctor sealed off not just from the patient but also from his own emotional responsiveness. Supererogation had no appeal for this new thinking. It was not simply frowned upon, rather we could say that doctors did not know what to make of the idea: it was an unwelcome intruder from beyond their professional estate.

3.2 Part Two: The Nineteenth Century

In the nineteenth century we find the growing prevalence of codes of practice, along with a sense of self-importance of the men who formulated them, a development I name, 'The Call of Nobility'. [254] Also apparent is the difficulty of translating such codes into the precise and mundane guidance which would be required in ordinary medical practice.

3.2.1 The Call of Nobility

I have chosen this expression to capture the sense of doctors being above the fray, removed from the suffering of their patients. There is a sense of doctors struggling beyond their strength for the sake of others, at a cost which is not to be regarded. At least, that was how doctors came to see themselves. They condescended to treat patients, but in return expected to be treated with deference, respect, and 'tenderness'. If vanity was the vice of Dr Burton, as satirized in Dr Slop, then pride was the vice of nineteenth century doctors who took increasingly self-satisfied views of their approach to patients.[255] Several quotations may be chosen, almost at random, to illustrate the charged atmosphere from these guides to medical conduct:

Firstly, an all-encompassing civilising mission:

> It is a delicate and noble task, by the judicious application of Public Hygiene, to prevent disease and to prolong life; and thus to increase the productive industry, and, without assuming the office of moral and religious teaching to add to the civilisation of an entire people.[256]

Secondly, for doctors to be treated with 'tenderness':

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[254] Rober Baker (ed) *The Codification of Medical Morality Historical and Philosophical Studies of the Formalization of Western Medical Morality in the Eighteenth and Nineteenth Century Vol 2 Anglo-American Medical Ethics and Medical Jurisprudence in the Nineteenth Century* (Dordrecht/Boston/London: Kluwer, 1995).

[255] Dr Fillgrave's pride is offended when he is superseded by another doctor in Anthony Trollope's novel, *Doctor Thorne* (Oxford, 156-169). Adam Smith gives a fine-grained distinction between vanity and pride: 'The proud man is sincere, and, in the bottom of his heart, is convinced of his own superiority'. The proud man is offended if not taken at his own valuation. The vain man is not convinced of his own superiority and 'is much more mortified than offended' if his superiority is not acknowledged. (Adam Smith, The Theory of Moral Sentiments, 300-305).

[256] from John Bell, 'An Introduction to the code of Medical Ethics', in Baker, 67.

> As it is the duty of a physician to advise, so has he a right to be attentively and respectfully listened to. Being required to expose his health and life for the benefit of the community, he has a just claim, in return, on all its members, collectively and individually, for aid to carry out his measures, and for all possible tenderness and regard to prevent needlessly harassing calls on his services and unnecessary exhaustion of his benevolent sympathies.[257]

Thirdly, for doctors to receive a dutiful quid pro quo:

> The members of the medical profession, upon whom are enjoined the performance of so many important and arduous duties towards 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 and require, that their patients should entertain a just sense of the duties which they owe to their medical attendants.[258]

And from *A Code of Medical Ethics,* by Jukes Styrap:

> A medical practitioner should not only be ever ready to obey the calls of the sick, but his mind should be imbued also with the greatness and responsibility of his mission; and his obligations are the more deep and enduring, as there is no tribunal other than his own conscience, to adjudge penalties for carelessness or neglect.[259]

The call of nobility, that is for doctors to see themselves as acting nobly, is a constant trope. While there is a grandiosity in the American codes, there is perceptible in the British codes a falling back onto the tradition of medical jurisprudence with its legalistic tone. Such approaches lead to supererogation falling out of the picture, for the guidance suggests that the burden of the doctor's work alone will lead to exhaustion. Duty has become so all-encompassing, albeit vague and inflated, that there is no space beyond duty where the concept of supererogation might be found; it is simply out of sight.

The call of nobility is further reinforced by doctors' conflation of self-promotion and self-deception , e.g., 'There is no profession, by the members of which, eleemosynary

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257 Baker, 66.
258 from Isaac Hays, 'Code of Ethics' , in Baker, 77.
259 Baker, 149.

services are more liberally dispensed, than the medical, but justice should be placed to the performance of such good offices.'[260] That suggests that exceptional service, if that is what is being referred to, should be met by a *quid pro quo* of thankful recognition; and this seems far removed from the unqualified service to others which supererogation calls for. This colonisation of fine feelings for themselves goes hand in hand with an expulsion of undesirable pretenders who threaten doctors' views of themselves:

> Medical ethics cannot be so divided as that one part shall obtain the full and proper force of moral obligations on physicians universally and, at the same time, the other be construed in such a way as to free society from all restrictions in its conduct to them; leaving it to the caprice of the hour to determine whether the truly learned shall be overlooked in favour of ignorant pretenders - persons destitute alike of original talent and acquired fitness. [261]

We wonder at the difficulties faced by practitioners who sought guidance on how to translate such codes into behaviour at the bedside. There is a tension between the desire to help and the handicapped nature of our attempts to do so. An example of this tension is found in George Eliot's *Middlemarch,* a novel to be discussed in chapter **7**:

> The element of tragedy which lies in the very fact of frequency, has not yet wrought itself into the coarse emotion of mankind; and perhaps our frames could hardly bear much of it. If we had a keen vision and feeling of all ordinary human life, it would be like hearing the grass grow and the squirrel's heart beat, and we should die of that roar which lies on the other side of silence. As it is, the quickest of us walk about well wadded with stupidity.[262]

The difficulty lies in just this gap: between the suffering of patients running up against the necessary 'wadding' required for the doctor's work to be done. Of course some fine balancing is required; after all, surgeons need to *temporarily* put their sensitivity to one side if they are to get on with the work in hand. It is the sheer exposure of doctors to suffering which tempts them to display such hardness of hearing; then the

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260 Baker, 168.
261 Baker, 66-67.
262 George Eliot, *Middlemarch* (Oxford),182.

overbearing, professional side comes to the fore and the moral obligations between us are put to one side.

In short, I see in these aspirations to a noble view a growing gap between doctors and patients, with a privileging of professional over ordinary person-to-person attitudes.

3.2.2 The Dehiscence of Medicine

Here we reach the dehiscence of medicine, the gap between theory and practice, especially the gap between codification and what happens at the bedside. In surgery a dehiscence or a non-union occurs when the edges of a wound which have been brought together fall apart when the sutures are removed. Primary healing has failed; further surgery and good nutrition are needed for secondary healing to take place. It is in a separate category from 'aporia', a term which features in *Postmodern Ethics*, by Zygmunt Bauman.[263] He defines aporia as, 'in a nutshell, a contradiction that cannot be overcome, one that results in a conflict that cannot be resolved'.[264] An aporia is intrinsically irresolvable while a medical dehiscence can be resolved, though it calls for a doctor to display von Wright's third variety of goodness, the giving of oneself. We can see the dehiscence of medicine in the contradiction between what duty prescribes and what the patient seeks. Following Bauman's analysis we can say that in modernity it was thought that the contradiction could be overcome, that patient education and the management of demand, along with doctors' increased training and efficiency, could close the gap. Bauman states that, 'Modernity knew it was deeply wounded - but thought the wound curable. And thus it never ceased to look for a healing ointment'.[265] But it was looking in the wrong place, thinking more of the same, more resources or funding, could do the trick. As we know, more research leads to the recognition of more disorders which call for diagnosis and treatment, and the possibilities are endless. The 'medicalisation' of the menopause is an example given by Roy Porter in the sobering conclusion to his medical history.[266] I hope to show that this gap in medicine can be bridged after all, and I propose thinking of

263 Zygmunt Bauman, *Postmodern Ethics* (Oxford: Blackwell, 2004).
264 Bauman, 8.
265 Bauman, 8.
266 Porter, 718.

supererogation in the spirit of a surgical dressing: I therefore prefer the term dehiscence to aporia.

Dehiscence has its origins in the very nature of medical practice. There is a formal dehiscence, in that curative treatments eventually fail and we all die. A subtle dehiscence results from the fact that doctors continually fall back on theory, often beyond the understanding of sick patients; this stems from the triangular relationship between the doctor, the patient and the theory, with two against one being a constantly recurring danger. In the age of the four humours, for example, at a time when blood letting was believed to correct an imbalance, a doctor might have bled a patient once, then, finding no improvement, conclude that the theory had not been applied vigorously enough and so bled the patient a second time. We would now ascribe the patient's collapse to low blood pressure and a failing circulation, but the death of a patient might have simply confirmed the strength of the theory for a mediaeval practitioner. A modern parallel would be where blood tests show no abnormality and the doctor then says, 'Nothing's showing up, so just see how you go!', here putting more faith in the laboratory rather than exploring the patient's complaint further.

I perceive a tragic quality to this aspect of medical practice because doctors are well intentioned towards patients; the gap arises from doctors' looking in the wrong direction, away from the patient as person and towards the patient as an interesting case of disease. It is a subtle shift, perhaps comparable to the change in direction from the true North Pole to the magnetic North Pole: only a slight shift at the beginning of the journey results in a wide deviation at the end.

The dehiscence becomes apparent in the nineteenth century, partly because we have greater knowledge of consultations than in earlier times. Various elements contributed to this separation and I now describe two of them: firstly there was a change in organisation and secondly there was a change in perception.

3.2.3 The Birth of the Clinic

Towards the end of the eighteenth century and in the early nineteenth century a profound organisational change took place: the birth of the clinic as described by Michel Foucault.[267] Patients who had once been seen at home were increasingly organised into out-patient clinics in teaching hospitals, with separate clinics devoted to particular disorders. This had the tendency to shift the perception of doctors into viewing patients as representatives of diseases rather than as individuals. A synergy took place which was of benefit to doctors and patients, although doctors were in control of the clinic space and could organise it to suit themselves. Patients became 'cases': a case of syphilis; a case of consumption; a case of rickets, and so on. Thus the patient's individuality became subsumed within a spectrum of cases of disease, from mild to severe, with patient numbering forwarding this ranking. The medical gaze ('le regard medical' of Foucault) was not just a new way of penetrating deeper into the patient's illness, discerning symptoms, signs and pathological changes; it amounted to a way of sidelining individuals while the important battle against disease took place.

Clinics were painted with whitewash, which was thought to be antiseptic, and patients were made to dress in simple, ill-fitting gowns. The privileged presence of the doctor contrasted with the degraded presence of the patient, though this was hidden from view by the benefits which the clinics brought about. Patients were gathered into the sheepfold of the clinic; identity might be lost, but new treatments could be tested all the more efficiently.

I remember the demarcated spaces of the clinic: the consultant behind the desk, with a row of medical students ranged behind like the chorus supporting the soloist. The patient was brought in by the nurse, told where to sit and silenced into submission. In such cases, the teaching of the medical students easily led to the patient being

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267 Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception* First published in France in 1963 *(Naissance de la Clinique: Une Archéologie du Regard Médicale)*. First publication in England in 1976.

discounted. The point here is that attempts to increase the efficiency of medical practice can have unintended consequences, separating us from patients in the person-to-person mode I have described.

3.2.4 Romantic Medicine

This dehiscence can also be discerned in medical practice during the early nineteenth century. There was a flourishing of medical theory, especially in London. In *Romantic Medicine and John Keats,* Hermione de Almeida describes the outpouring of new theory and inspired practice amongst the doctors, poets and philosophers of the age.[268] Keats studied medicine at Guy's Hospital, London, and his education went hand in hand with new thinking in philosophy and politics. This influence can be discerned in poems such as *Endymion.* Something of the rarefied flavour of the period can also be found in the works of Friedrich Schiller, who had been a regimental doctor before turning to poetry and drama. Similarly inspired practice has been discerned in Edinburgh where the literary and medical contributions to the periodical, *Blackwood's Edinburgh Magazine,* have been analysed. Doctors in the early decades of the nineteenth century were expected to be literary men. [269]

If the patient had been reduced to the passive bearer of disease then the doctor had become the detective, refining diagnostic skills and probing his way into the mind and body. For avant-garde doctors medicine had become a display of intellect, using the patient as a means to an end. There was a heady mixture of the mundane and the esoteric: anatomical studies, for example, found their base expression in dissection of the body, with grave robbers providing the raw material, yet this ran alongside a rarefied appreciation of the Elgin Marbles, with their ancient beauty praised by Hazlitt for anatomical excellence.[270]

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[268] Hermione de Almeida, *Romantic Medicine and John Keats* (New York, Oxford: Oxford University Press, 1991).

[269] Megan Coyer, *Literature and Medicine in the Nineteenth Century Periodical Press* (Edinburgh: Edinburgh University Press, 2017).

[270] William Hazlitt likened looking at the Elgin marbles 'as the expert angler knows from an undulation on the surface of the water what fish is playing with his bait beneath it', De Almeida, 47.

Aesthetic refinement was achieved by a search for what was hidden from view. Perhaps patients were seen as obscure, rather like the newly-discovered Rosetta Stone, [271] for interest was not in the stone itself but in the signs engraved on its surface, which scholars ached to translate and interpret. In the same way doctors overlooked the patient and became ever more watchful of signs found on examination which could herald what was taking place within. British medicine had moved far from its foundations in the modest and careful bedside observations of Thomas Sydenham (1624-1689), the 'English Hippocrates'. The stethoscope, for example, designed by Rene Laennec in 1816, gave rise to the discrimination of sounds coming from the heart and lungs. The old appreciation of the heart's *lub-dub*, heard by applying the ear to the chest, was augmented by the discovery of other sounds, triple and gallop rhythms and ejection systolic clicks. Not content with this plethora of signs, Romantic physicians transformed their practice into some ethereal search for meaning beyond the patient's suffering. De Almeida writes of an 'insightful and visionary way of knowing',[272] and we can see that this amounted to a new way of seeing, both of what was found in dissection and the speculative insights into the nature of health and disease. One cannot help but see a dehiscence here, between the suffering patient's experience and the heady, overweening vision of the doctor.

This intensity of vision was furthered by the introduction into landscape drawing and medical practice of the camera lucida which enabled the viewer to see something from two perspectives, 'one distant, the other immediately at hand - as one continuous experience of vision'.[273] This visual aid was an invitation to grandiosity for doctors, seeing an object both in detailed view and as something much bigger than itself. Thus the doctor had a privileged view denied to patients in their hospital beds or ill-fitting gowns.[274]

For Foucault, 'the clinical eye discovers a kinship with a new sense'; this was indeed a new epistemology. The distinction between symptoms and signs evolved and

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271 The Rosetta Stone in the British Museum is an ancient Egyptian stele on whose surface are carved words in three languages, one of which is Greek, offering the tantalising prospect of finally being able to decipher ancient languages.

272 De Almeida, 47.

273 De Almeida, 49.

274 Even Wordsworth seems to have jumped onto this bandwagon: 'Minds that have nothing to confer Find little to perceive', from 'Yes,! Thou Art Fair, Yet Be Not Moved'.

matured, with the capricious symptoms being supplemented, if not supplanted, by the doctor's elicitation of signs of disease. As with the hieroglyphs on the Rosetta stone, clinical signs became something only the doctors could detect and elucidate. The patient's body thus revealed things that the patient was unaware of, and the body as a repository of disease became an object which only someone acquainted with medical hieroglyphics could make any sense of at all.

When I stated that doctors displayed a neutrality towards suffering I did not want to accuse them of indifference, but rather a distancing from themselves of such suffering. By embracing the anatomical and philosophical pursuit of disease they made use of the patient's body, and by conquering the disease they could thus vanquish the suffering. Romantic doctors sought treatment for 'Disorders of the Imagination', for example, in the riches of Romantic poetry, which could inspire them to imaginative striving for mastery of all they surveyed on the wards. I see here a mastery of the patient and their disease in a complete colonisation of the patient's experience by the profession, with little left to be done in the way of supererogatory striving. I see sensitive doctors being beguiled by these imaginative excursions because of a lack of effective remedies for most diseases.

This further separation of doctors from their healing powers has been described by Brittany Pladek in *The Poetics of Palliation: Romantic Literary Therapy 1790-1850,*[275] and I suggest that the penetration of poets into the realm of healing simply underlines the fact that doctors were *not* extending themselves into that imaginative and creative realm beyond ordinary dutiful practice where qualitative supererogatory healing might have taken to place. Doctors were not extending themselves because poets did it for them.

3.2.6. Conclusion

Supererogation was lost sight of by doctors from Descartes onwards. The preponderance of Descartes' philosophy redirected medical attention towards the body

[275] Brittany Pladek, *The Poetics of Palliation: Romantic Literary Therapy 1790-1850* (Liverpool: Liverpool University Press, 2019). It was thought that romantic poetry could have healing powers, but one wonders how far such effects could be expected to reach those who were illiterate.

of the patient, not the person. I have looked at the growing influence of the professionalization of medicine as represented by the *bravura* of Dr Tulp and his colleagues. The publication of codes of practice led to the separation of the profession from patients; the doctors became sequestered behind the defensive walls of their own estate, with unlicensed practitioners expelled and derided. I have described two examples of dehiscence in medicine: the organisation of patients into clinics, leading to patients becoming merely part of a group, and the heady effects of romanticism which led to doctors being deflected by the visionary spirit underpinning poetry of this period. These changes resulted in a widening gap between doctors and patients, not at all conducive to supererogation.

In this chapter I have explored the process by which supererogation was lost sight of by doctors, and in the next chapter I shall amplify this theme by showing how, for many doctors, duty came to be seen as all that was needed to be done and all that should be done.

4. Chapter Four: Duty Closing In

4.1 Introduction

I demonstrated in chapter 3 the ways in which supererogation was neglected as a result of the codification of professional behaviour, defining and narrowing doctors' concerns. That slippage from view amounts to a 'loss of problems' in the words of Wittgenstein. This chapter attempts to diagnose what is wrong. In the first part I describe how impoverished medicine has become because of this loss. I refer to the philosophy of literature as described by Martha C. Nussbaum, and I illustrate her work with a detailed look at two doctors in Virginia Woolf's novel, *Mrs Dalloway*. Woolf depicts their behaviour as a straight-jacket which prevents them reaching out to their patient; their sense of moral obligation has been constrained by professional modes of behaviour.

In the second part, by way of contrast, I look at the work of Emmanuel Levinas whose ideas of 'infinite responsibility' point to a challenge to the usual limited view of doctors' duties towards patients. With this challenge to doctors' peace of mind, I then describe some of the dysfunctional habits of thought and behaviour which continue to keep doctors separate from the suffering of patients.

4.1.2 Martha C. Nussbaum and the Philosophy of Literature

Nussbaum's philosophical and literary analysis of the works of Woolf, Henry James and Marcel Proust are of particular interest.[276] All three novelists avoid the obvious, dominant narratives of life; rather they are concerned with the texture of life lived in detail, all intensely observed. They teach us to look into the interstices of life, as Nussbaum describes:

> Schematic philosophers' examples almost always lack the particularity,

[276] Martha C. Nussbaum, *Love's Knowledge, Essays on Philosophy and Literature* (New York, Oxford: Oxford University Press, 1992).

> the emotive appeal, the absorbing plottedness, the variety and indeterminacy, of good fiction; they lack, too, good fiction's way of making the reader a participant and a friend; and we have argued that it is precisely in virtue of these structural characteristics that fiction can play the role it does in our reflective lives.[277]

Following Nussbaum, I would say that we cannot understand patients and indeed ourselves without a wide and deep understanding of human nature, and that can partly be experienced from literature.[278] Certainly literature and bioethics should make comfortable companions in furthering our understanding.[279] Philosophical and medical accounts, by contrast, are lacking in human emotion and attention. Doctors have shorn themselves of emotional connectivity with their patients, when they do in fact need to cultivate the practice of becoming 'a participant and a friend' of the patient before them, though great good sense is needed to judge this well. We can further say that the accounts of illness found in novels show what is omitted from medical discourse: a detachment from the suffering of patients. Doctors and patients are poorly served by this attitude which leads to such 'shallow and trivial' emotional responsiveness.

Nussbaum finds in literature 'a more supple and nuanced ethics', reacting against the 'fixity' of male-dominated ethics,[280] and she finds such nuance in the novels of Henry James. It is the complex detail which reveals the moral texture; by contrast she complained of 'the language of conventional philosophical prose, a style remarkably flat and lacking in wonder'.[281] As Jill Larson comments, referring to Nussbaum in *Love's Knowledge,*

> In her view, 'the particular is in some sense prior to general rules

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277 Nussbaum, 46.

278 'But the most essential and fundamental aspect of culture is the study of literature, and so is an education in how to picture and understand human situations.' Iris Murdoch, 'The Idea of Perfection' in *The Sovereignty of Good* (London: Routledge, 2014), 33.

279 'looking at bioethical problems from the perspective of two such closely related Humanities disciplines as philosophy and literature ought to be perfectly feasible'. Stephen Holland, 'Bioethics', in *Philosophical Books,* 47 (2006), 245-254, p.249.

280 Jill Larson, *Ethics and Narrative in the English Novel, 1880-1914* (Cambridge: Cambridge University Press, 2001), 96.

281 Nussbaum, *Loves' Knowledge,* 3.

> and principles' [. . .] reading a novel, then, can be 'a paradigm of moral activity' [. . .] because long narratives, by definition, unfold stories rich in complicated details. [282]

In medical terms this would suggest a focus on the individual patient, rather than the abstraction of 'cases' of which the patient is an exemplar. Literary sources are just as valid as medical case histories for students of medical practice, and one example might suffice to illustrate this point: the perceptive description of Dr John in *Villette*, where Charlotte Bronte gives a fine distinction between sympathy and what we would now call empathy.[283] It is hard to think of any comparable description written by a doctor on this topic.

We do not learn much of clinical use in reading about antiquarian medical treatments, but we do learn about ourselves.[284] Doctors can understand, for example, how the 'history of the presenting complaint' is very much an abstraction of what the patient might have told them, filtered and strained though the doctor's medical discourse. Similarly, doctors who refuse to incorporate the suffering of patients into their discourse have assumed what I name a 'sterilising stance' towards patients, something which is distressing to witness. Novels call on us to reflect continually on our behaviour and to be fully engaged with patients. Furthermore we should not believe that medical case histories are unquestionably 'objective', for by studying the narratives of such histories Tod Chambers has exposed the rhetorical devices doctors use to tilt their accounts in one direction or another.[285] For a study of such distancing

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[282] Larson, 4. The quotations in Larson's text are from *Loves' Knowledge,* pp.165, 148.

[283] '[T]he sympathetic faculty was not prominent in him: to feel, and to seize quickly another's feelings, are separate properties; a few constructions possess both, some neither. Dr John had the one gift in exquisite perfection; and because I have admitted that he was not endowed with the other in equal degree, the reader will considerately refrain from passing to an extreme, and pronouncing him as *un*-sympathizing, unfeeling: on the contrary he was a kind, generous man. Make your need know, his hand was open. Put your grief into words, he turned no deaf-ear. Expect refinements of perception, miracles of intuition, and realize disappointment'. Charlotte Bronte, *Villette* (Harmondsworth: Penguin, 1979), 264.
Here Dr John shows sympathy but not that active reaching out to another's distress. Empathy is non-judgemental and does not offer quick remedies (and so is perhaps hard for doctors to achieve). Many scholars have tried to distinguish them, e.g., *Forms of Fellow Feeling: Empathy, Sympathy, Concern and Moral Agency,* ed. by Neil Roughley, Thomas Schramme (Cambridge: Cambridge University Press, 2018).

[284] Mary Beard makes this point in relation to the value of the study of ancient history. Mary Beard, *SPQR: A History of Ancient Rome* (London: Profile Books, 2016), 535.

[285] Tod Chambers, *The Fiction of Bioethics: Cases as Literary Texts* (London: Routledge, 1999).

we now turn to Virginia Woolf's novel, *Mrs Dalloway,* and I wish to take a detailed look at this work in the light of the particularism of Nussbaum.

4.1.3 Virginia Woolf and *Mrs Dalloway* (1925)

Virginia Woolf is of interest for this thesis because of the unsatisfactory nature of her medical encounters. Her long history of mental illness made her aware of doctors' listening to her and yet missing the point. After one such consultation, for chronic sore throat, she was advised to practise 'equanimity', as if this simple mantra was likely to be of benefit![286] Her perception shows what was going on below the surface, and that is what I wish to probe.

This novel has been studied as an example of how literature can improve medical practice because the doctors' disengagement makes painful reading. Septimus Warren Smith, who suffers from mental illness, is attended by his GP, Dr Holmes, and a consultant psychiatrist, Sir William Bradshaw. They might have been drawn from Woolf's experience of consultations when younger. Both doctors pass by the patient like ships in the night. The GP is robustly matter-of-fact and hearty, full of common-sense views which miss the mark; for example, he asks his wife for a second plate of porridge for breakfast when he is feeling low. Indeed he is hide-bound by his own good health:[287] when the patient talks of suicide he replies, 'Didn't one owe perhaps a duty to one's wife?' The psychiatrist is assured and commanding; his diagnosis is centred on 'a lack of proportion', repeated like a mantra; indeed the patient is not spoken to in a way that he can understand. Septimus does commit suicide later in the novel; he is overwhelmed by the terror of his war experiences, and finally cannot bear the thought of being taken into hospital against his will.

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[286] 'Wed. 16 August 1922, [. . .] Very softly, wisely & with extreme deliberation. "Equanimity - practise equanimity Mrs Woolf" he said, as I left; an unnecessary interview from my point of view'. *The Diaries of Virginia Woolf; 2: 1920-1924* ed. by Anne Oliver Bell (London: Hogarth Press, 1978), 189. The term 'Equanimity' was advised by Sir William Osler, Regius Professor of Medicine at Oxford. In an essay entitled 'Aequanimitas' (1880) he advocated 'Imperturbability' and 'Equanimity', though these were recommended for doctors, not patients!

[287] 'Large, fresh-coloured, handsome, flicking his boots, looking in the glass, he brushed it all aside - nerve symptoms and nothing more, he said'. (Woolf, *Mrs Dalloway,* 101).

What has gone wrong here? We can look to the work of G. H. von Wright and his analysis of goodness.[288] He distinguished between technical and instrumental goodness, the former concerned with the formation of a tool or the training of a person, the latter concerned with how that tool or person proves successful in use. The two can intertwine: doctors might undertake training in a new technique which not only enables them to diagnose more widely and more accurately but also makes them better instrumentally, all the more likely to cure the sick. Von Wright describes a third category: 'excellence in the creative arts',[289] and he adds, 'The professional skill e.g., of a doctor or a teacher, may rise to the level of creative genius'. He distinguishes between a good painter and the one who rises to the ranks of *artist*, whose excellence lies beyond the testing appropriate to membership of the lower two categories. One could imagine a doctor who is not only excellent in the field but who also starts to make connections between previously unrelated diseases and whose work reaches beyond *goodness* into *greatness*.

We could say that the doctors in *Mrs Dalloway* might well be technically and instrumentally good enough, at least as judged for themselves, but they lack the third variety of goodness; they do not throw themselves forward. The psychiatrist has achieved distinction with a knighthood and a practice in Harley Street, but both seem constrained within their own notion of duty without any straining beyond their usual reach: they lack the imaginative grasp of what the patient might be feeling. Importantly though, doctors reading the novel might find little amiss with their behaviour. This novel has been studied as an example of how literature might improve the sensitivity of medical students and so make them better doctors,[290] yet I want to go further and claim that doctors might improve their practice by thinking of supererogation as a conceptual engine to drive them in a better direction.

The doctors in the novel appear to be listening but do not hear what the patient is saying; there is no sense of sympathetic striving to understand the patient's experience. Good practice is about accompanying the patient on the road to recovery, or sustaining the patient when cure is not possible. Sir Thomas Browne gives a

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288 G. H. von Wright, *The Varieties of Goodness* (London: Routledge & Kegan Paul, 1963).
289 Von Wright, 39.
290 Robin Downie and Jane Macnaughton, *Bioethics and the Humanities: Attitudes and Perceptions* (Abingdon: Routledge Cavendish, 2007), 144-147.

moving account of the alleviation of suffering by such an approach.[291] That is the nature of Woolf's condemnation of their failure, with the psychiatrist's attendance at Mrs Dalloway's party on the evening of the suicide pointing up the gulf between the robust good health of the doctors, that thrusts them into the world, and the patient's poor health that leaves him shrinking into despair. The party conversation at the end, the culmination of Mrs Dalloway's day, contrasts so sharply with the despair of the patient: 'What business had the Bradshaws to talk of death at her party? A young man had killed himself. And they talked of it at her party - the Bradshaws talked of death'.

In short it is a novel in which the doctors take too superficial a view of the patient; seen in the light of a case history, it underlines the fact that all three varieties of goodness should be acknowledged by doctors.

4.1.4 Acquiring Goodness

We might hope that doctors want to extend their reach, yet how are they to do this? We wish to think of doctors as having particular strengths, being expert in some technical aspects, but we also want them to be virtuous. Perhaps we should value strength of character more highly than intellectual strength, something nowadays neglected in the selection of medical students.[292] We have lost confidence in discerning such things. We like to find people to have a full share of the virtues, to be well-rounded and able to respond appropriately. Should we expect doctors to work towards acquiring such a well-rounded personality? A musical analogy might help. In the *Well-Tempered Clavier* from 1722 Bach composed preludes and fugues in all 24 of the major and minor keys. This depended on a system of tuning (the 'temperament') to balance the harmonics between one key and the next so as to give equal prominence to each key, one after the other. The price paid for this equal-handedness was a slight tension within the harmonics of each key, perceptible to a musician though not to most of us. Other ways of tuning a piano, such as the

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[291] 'It is an act within the power of charity, to translate a passion out of one breast into another, and to divide a sorrow almost out of itself; for an affliction, like a dimension, may be so divided, as, if not indivisible, at least to become insensible.' is at the heart of this long passage. Browne, 73.

[292] Stanley M. Hauerwas, 'On Medicine and Virtue: A Response' in *Virtue and Medicine Explorations in the Character of Medicine,* ed. by Earl E. Shelp (Dordrecht. Reidel, 1985), 355.

temperament devised by Rameau,[293] got rid of those slight tensions but at the price of making the remote keys on the piano sound almost unbearable, the growing discordance between the harmonics creating a so-called 'wolf' sound.

If we extend this musical analogy to the virtues of medical practice, and that is not implausible given the eighteenth century belief that musical keys were indicative of particular moods and attitudes, then we could say that virtuous doctors, the well-tempered ones, are going to have some discrepancy between all of the various virtues - they will not blend as perfectly as one might wish. On the other hand, closer harmony between the commonly demonstrated virtues can only be achieved at the cost of a 'wolf' sounding off when the remote virtues come into play. A 'well-tempered' doctor would thus be harmonious as each virtue came into play, one after the other, yet have some rough edges and irritabilities if pressed too closely. The smooth and rounded doctor, tuned Rameau-style, on the other hand, would be plausibly suave on first impression but shade off into grating false harmonies when stressed.[294]

We see a distorted temperament in Sir William Bradshaw when he is drawn into a very remote key, for he is at the elegant party just after Septimus has committed suicide. The discordance is perceived by Mrs Dalloway when Sir William tries to remain at his finest social self in the midst of his wife's distress at their late arrival, yet *she* sees through him:

> Why did the sight of him, talking to Richard, curl her up? He looked what he was, a great doctor . . . He had to decide questions of appalling difficulty. Yet - what she felt was, one wouldn't like for Sir William to see one unhappy. No; no that man.[295]

Sir William, distinguished and urbane as he might be, has not been tuned to our liking. On the other hand, we warm to those fictional doctors whose temperament is equally balanced, though grating when pressed too hard; we find these characteristics

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293 Jean-Phillippe Rameau (1683-1764), important music theorist and composer.

294 The relationship of virtue and music is the subject of academic research, e.g., David Carr, 'The Significance of Music for the Moral and Spiritual Cultivation of Music', *Philosophy of Music Education Review,* 14 (2006),103-117.

295 Woolf, *Mrs Dalloway*, 200.

in television doctors such as Dr Finlay in the 1960s serial.[296] A nineteenth century portrayal is found in Dr Thorne in Trollope's novel of that name. Similarly with Dr Thorne, it is the surface acerbities which obscure to some extent his deeper virtue and hide his good heart. There would be no difficulty in owning one's unhappiness to him; while it seems that, if impressions from boyhood can be trusted, Dr Finlay also explored his patients' unhappiness as a means of restoring them to health. Put back into the musical theme, we could say that Sir William ignored disharmonies by avoiding remote keys, while Dr Thorne and Dr Finlay listened out for disharmony between themselves and their patients and tried to correct the tuning while the music was still being played.

4.1.5 Supererogation playing a part

Could Sir William be retrained into becoming more like Dr Thorne or Dr Finlay? Sir William might say that nothing was wrong: he did his duty, was conscientious, and had a distinguished place in the profession. He might argue that the modern day emphasis on empathy was not required, preferring to show a matter-of-fact concentration on the patient's illness.[297] And if we challenged him for choosing to go to Mrs Dalloway's party rather than going to see the widow of Septimus, then he might respond that it was his duty to attend the party; after all, it would have been disrespectful not to go (for indeed the Prime Minister was expected to attend). How could we make headway against that?

It might be claimed that the bereavement visit was supererogatory, given that it would not have been taken-for-granted, and so there is little to be said beyond questions of etiquette and social discernment. How could we make Sir William aware, from our point of view, that his judgement was askew? What can we do about such insensibility? Should we just leave it at that and encourage such doctors to enter areas of medicine where little 'face-to-face' contact is required? What Mrs Dalloway reacted against was the disposition of Sir William. Bernard Williams has commented

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296 *Dr Finlay's Casebook,* based on the novels of A. J. Cronin, was broadcast by the BBC from 1962-1971. The popularity of the series suggests that Dr Finlay portrayed the type of doctor viewers wished to find.

297 Paul Bloom, *Against Empathy: The Case for Rational Compassion* (London: Vintage, 2018).

on this, the disposition view.[298] For Mrs Dalloway, as with Williams, it was not what was said, or indeed even thought (in other words, not a 'cognitive capacity') but something about his disposition, more a way of seeing.

'Disposition' in philosophy derives from Aristotle's *Nichomachean Ethics;* it is a translation of 'hexis', now more commonly known as 'habitus'. It is that perduring substrate of character which is inculcated by repetition and expressed in action. We might not always be aware of our disposition. This touches on a remark in Stephen Mulhall's commentary on Heidegger in which a paradox from Augustine is noted: 'that the self's closeness to itself makes it into a land of labour and inordinate sweat to the explorer'.[299] That perspective is one reason why we need close personal relationships, so that others can lovingly point out our faults and attitudes, giving us opportunity for redress. Wittgenstein and Heidegger both pick up this point from Augustine, that we are blind to ourselves; indeed they see the origins of philosophy in this sense of lostness.[300]

This thesis is arguing for a different way of seeing, and the difficulty is persuading people that there are indeed other ways of seeing. A comparison might be made with the climber and mountaineer in the Cairngorms, Nan Shepherd, who showed us how to see mountains differently; indeed she was intent on 'picking up the stick at the other end', establishing a new way of mountaineering, not in a geographical sense but psychologically. She preferred walking around a mountain rather than scrambling to the top in triumph, an altogether more spiritual exploration.[301] In such a manner Mrs Dalloway was able to walk *into* the doctor, to perceive something not to her liking. This might have been a projection of Woolf's feelings towards doctors in authority, and we know from her diaries how she suffered at their hands.

Sir Williams' disposition is one of self-containment, keeping him costive in his range of emotions. He did not know his way about himself. We might now say he suffers

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298 Bernard Williams, *Philosophy as a Humanistic Discipline* (Woodstock, Oxfordshire: Princeton University Press, 2008), 67-75.

299 Stephen Mulhall, *Inheritance and Originality: Wittgenstein, Heidegger, Kierkegaard* (Oxford: Clarendon Press, 2001), 217.

300 'A philosophical problem has the form, "I don't know my way about" (Ich kenne mich nicht aus)'. Mulhall, 151.

301 Nan Shepherd, *The Living Mountain* (Edinburgh: Canongate, 2011).

from a 'blind spot'; this is one of the four aspects of the self from the Johari Window,[302] described in 1955 by Luft and Ingham, which is used in counselling for promoting self-awareness. But it is not the doctor who suddenly see things anew, nor his wife, embarrassed by their late arrival, rather it is Mrs Dalloway herself. She has a *Gestalt* moment when she happens to look out of the window and sees a neighbour in a window opposite, getting ready for bed:

> She parted the curtains; she looked. Oh, but how surprising! - in the room opposite the old lady stared straight at her! She was going to bed. And the sky. It will not be a solemn sky, she had thought, it will be a dusky sky, turning away its cheek in beauty.[303]

That turn in the novel leads to Mrs Dalloway seeing herself, finding herself anew. I believe it signals a recovery of herself, away from the evanescent concerns of the party, towards a deeply felt sense of her own vulnerability. It is noted earlier in the novel that she had recovered from Spanish Flu but had a heart condition as a result, and there are indications throughout the novel of the ineluctable passage of time, all heightened by the losses of the First World War.[304] Mrs Dalloway shows a muted sense of recovery but with acknowledgement of her vulnerability.

We could wish that Sir William might have had a *Gestalt* moment, to recognise his own vulnerability. Again the distinction noted by Mulhall comes to our aid; it is likely that Sir William's rigidity arises from his seeing duty in terms of the 'myth of command, a constraint upon the will'.[305] On the other hand 'the myth of intimation, with this talk of an inner voice' would allow a sense of individual responsiveness to each situation,[306] a flexibility, with the possibility of far-flung reactions into the realm of supererogation. It is this 'intimation' response which provides 'a moment of genuinely individual judgement'. In fact Wittgenstein's thought on this matter seems pleasingly subtle; he avoids a binary cleavage, rather seeing 'norms as coercing our wills'; 'internalising their authority makes us what we are - makes us human, fellow

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302 The other three windows are the *arena*, the *facade* and the *unknown*. The windows concern what we know of ourselves in the light of what others know about us.
303 Woolf, *Mrs Dalloway,* 204.
304 On the morning of the party Mrs Dalloway is mending a tear in her dress when on an old friend arrives from India.
305 Mulhall, 150.
306 Mulhall, 150.

inhabitants of a culture'. [307] As noted above, both ways of thinking are important for a doctor.

Can doctors be pointed in a better direction? I suggest there are four stages. Firstly, it is important to encourage the habit of listening for such an 'intimation' response, heard in the background of their usual manner of speaking.[308] Secondly, doctors would do better to be open to challenge from patients and relatives, and should themselves continually reflect on their behaviour, accept the fact that they are sometimes wrong and bring an attitude of respect to the worries of patients and their families. Thirdly, continual self-reflection can be augmented by reading about doctors in novels. Large compilations of doctors in literature, with critical commentary, have recently been made.[309] Fourthly, and in the spirit of supererogation, we might ask, 'What more could I do for this patient?' I claim that the doctors in *Mrs Dalloway* might benefit from adopting all four stages.

4.1.6 'Flipping' Duty and Supererogation

What is emerging from these ideas is the peculiarity which is at the heart of this thesis, that what we extol as duty, even when fully performed, might fall short of what is required. What needs to be explained is how we have come to be satisfied with duty. This is a reversal of our usual way of thinking. We have set up a barrier between duty and supererogation so that we can preserve our resources, and to ensure that we do the minimum required, yet it is a pity even so; a diminution of ourselves in relation to others.

In drawing up a balance sheet, I start with the good that Sir William might have brought about. It could be claimed that his solidity and four-square limitations might have proved comforting to disturbed patients who were looking for a feel of ordinary normality. Some patients might need to be firmly guided, others might need to be

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307 Mulhall, 150.

308 Wordsworth's great poem, *Ode on Intimations of Immortality from Recollections of Early Childhood,* acts as an inspiration and a template for accessing this state of mind. 'We will grieve not, rather find | Strength in what remains behind; | In the primal sympathy | Which having been must ever be'. William Wordsworth, *Wordsworth, Poetical Works,* ed. by Thomas Hutchinson (Oxford: Oxford University Press, 1990), 460-462

309 Solomon Posen, *The Doctor in Literature: Satisfaction or Resentment* (Oxford: Radcliffe, 2005).

walked around more cautiously to find a point of entry to their fears. On the morning of the party Mrs Dalloway had felt 'the terror; the overwhelming incapacity [. . .] there was in the depths of her heart an awful fear', but that had dissipated as she watched her husband reading *The Times* (this is a touching note as Virginia Woolf found her own husband's presence a stabilising influence when she was unwell). Sir William might have left all those tender-hearted concerns to the chaplain, the nurse, the relatives, to dissipate with prayers and words of comfort. He might have been aware of existential fears but believed they were best carried away by others. So perhaps he was not to be criticised after all; furthermore there are 'hard-to-help' patients who are suspicious of doctors, and some are so recalcitrant that they cannot be helped until they are detained against their will, and that requires legal safeguards.

On the debit side of the balance sheet, Mrs Dalloway and Rezia, the wife of Septimus, both see something almost hateful in him. Sir William, I suggest, is too satisfied with his performance, too safely ensconced, and not dallying on the border between duty and supererogation. There is nothing liminal about him. Such certainty is a liability however, for we want doctors to be partially 'lost', at least to question in what direction they are going. For Mrs Dalloway it was her fear in his presence which provoked such a strong reaction in her; and both Septimus and his wife were afraid of him too.[310] That is something which Sir William was not alive to: he was too much in command, using his fluency in language to make the patient submit, and if Septimus's inarticulacy was annoying then that too should have been recognised as indicative of his fear.[311] In short, Sir William was too constrained by his sense of duty and needed to extend himself by acquiring a revitalised disposition.

4.1.7 The Mystery

One of the mysteries about doctors, who might never have heard of supererogation, is that they have a clear sense of where their duties lie. That does not seem difficult, and is largely based on the actions of their predecessors and colleagues in similar

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310 '"Trust everything to me," he said, and dismissed them. Never, never had Rezia felt such agony in her life! She had asked for help, and had been deserted! He had failed them! Sir William Bradshaw was not a nice man'. Woolf, *Mrs Dalloway*, 109.

311 'If to speak is to speak of what one wants, of what matters most, then to speak is always to run the risk of humiliation'. Adam Phillips, *The Beast in the Nursery* (London: Faber and Faber, 1999), 41.

situations. The origins of this taken-for-granted quality are not clear. Hauerwas points the way in his study of casuistry.[312] He describes the sort of 'trolley problem', common in bioethics texts, where a person trapped underground might be blown out of the hole using dynamite (conveniently to hand) so that four other persons, otherwise doomed to drown by rising water, might be saved. Something similar is happening with Sir William; we feel that he might not fret at the loss of one patient if four others were saved, and further, it would hardly matter which one of the five had to go (that corrosive lack of fine-tuning to the individual is at the heart of *Mrs Dalloway*, indeed it caused distress to Woolf herself when consulting doctors). Dr Holmes and Sir William Bradshaw see Septimus generically; he suffers individually and alone. That lack of attention to persons in consequentialist thinking, commonly found in biomedical texts, with the damage it does to individuals and to the fabric of society, has been condemned by philosophers, notably by John Finnis.[313] In the next section I explore how this lack of attention to persons might be overcome.

4.1.8 A Question of Trust

The presuppositions on which consultations are based are so much part of the furniture of the consulting room that we fail to notice their presence. One of these items of furniture, indeed the floorboards on which we stand, is the trust between doctor and patient. In an earlier thesis[314] I distinguished between reliance and trust, and I came to the conclusion that usually we do not need to look for trust and trustworthiness; we can place our faith in the reliability of doctors to do their work. By contrast, when doctor and patient are working beyond the ordinary boundaries, when they are not standing on secure foundations, then trust and trustworthiness are required, and strongly so.

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312 Stanley Hauerwas, 'Casuistry in Context: The Need for Tradition' in *The Hauerwas Reader,* ed. by John Berkman and Michael Cartwright (Durham: Duke University Press, 2001), 266-284.

313 'But consequentialist reasoning is arbitrary and senseless, not just in one respect but in many. So we are left with the fact that such a killing is an act which of itself does nothing but damage the basic value of life' (John Finnis, *Natural Law & Natural Rights* (Oxford: Oxford University Press, 2011), 119.

314 David Allen Stocks, 'An Analysis of the Nature of Trust and its Role in the Patient-Doctor Relationship' (Unpublished MPhil thesis, The University of York, 2013).

Once again we return to Sir William. He does what he says, if in a rather mechanical way, but his trustworthiness is suspect for he is too bland about prospects for recovery and he fails to acknowledge the anxiety of Septimus and his wife. All three needed to be on the trust/trustworthy axis, not on the reliance/reliability axis which is all he had to offer. With this failure in mind, perhaps we might feel sorry for him. It sounds like Woolf set him up for failure. There are hints that the novel was informed by her own experience; for example, a similar doctor advised Woolf and her husband not to have children, for fear of pregnancy making her mental illness worse.[315]

4.1.9 A Long Circumambulation

I suggest that duty without the virtues simply falls short; that is, if we are to be satisfied with the merely dutiful then something profound would be missing. Virtues are not the top dressing of life, they should run all the way down. Gregory M. Reichberg[316] highlights the distinction in Aquinas between the moral and the intellectual virtues, and we could say that Sir William shows a discrepancy between the two analogical kinds: he has the intellectual virtues - the capacity to perform - but fails in application. Reichberg gives the example of 'an eminent surgeon who may nevertheless refuse to operate on a sick individual who clearly stands to benefit from this intervention'.[317] We deplore that lack of cohesion between the two species of virtue.

We are looking for engagement from doctors, something apparent even in the clips of Dr Finlay who showed what engagement is about. It is the glue that holds together the two analogical kinds of virtue, so that doctors who have the competence to see what needs to be done and then act upon it. Aquinas, thinking of Aristotle, 'notes that, in its full fledged-meaning, virtue denotes a habit that "makes its possessor good and his operation good likewise".'[318] It is only by straddling the boundary between

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315 'Sir William not only prospered himself but made England prosper, secluded her lunatics, forbade childbirth, penalised despair, made it impossible for the unfit to propagate their views until they, too, shared his sense of proportion [. . .] ' Woolf, *Mrs Dalloway,*110.

316 Gregory M. Reichberg, 'The Intellectual Virtues (Ia IIae, qq.57-58)' in *The Ethics of Aquinas,* ed. Stephen J. Pope (Washington: Georgetown University Press, 2002).

317 Reichberg, 141.

318 Reichberg, 141, and Aquinas, *Summa Theologica,* 1a 2ae. 56. 3, who is referring to Aristotle's *Nichomachean Ethics.*

duty and supererogation that doctors can grasp the profundity of what more might be done for patients, and then appraise prudentially what might be achieved in practice.

To end our discussion of Sir William, I find that he is reliable but not trustworthy. How does this deficiency map onto moral theology, especially that of Aquinas? Jean Porter gives an illustrative analysis in her study of the dialectics of Aquinas in relation to the virtues.[319] In this light we can see Sir William's reliability as corresponding to the first half of the goodness aimed at, that half consisting of those 'external normative criteria'[320] which are the objective standards which need to be met for an action to be counted as sound. The second half is more important, for that consists of 'the perfection of the agent's powers',[321] in other words a determined effort to continually improve, to be reflective, and to become adept at judging one's performance. That would represent the trust/trustworthy part of the performance. It is this richness of response, indicating a good character of the agent, which we crave to see, especially in doctors when lives are at stake. As Porter states,

> It is not enough for the individual to do the right sorts of things, in order to be truly virtuous; she must do them well, that is to say out of well-formed passions, a good will, and intelligent judgement. Done in this way, a particular act is good, not only by the external standards of the basic moral notions, but also as a manifestation of the perfection of the individual's powers of action.[322]

Put another way, we would want Sir William Bradshaw to *enact* goodness, not just to represent it as a member of the medical profession. This is something that cannot be achieved without self-knowledge, and that would involve, as MacIntyre points out, repentance for past blindness and self-deception.[323] Thus self-knowledge is a painful business. It requires courage, something which becomes harder to access the older we become, primarily because we might then have to acknowledge the cumulative harm we have done to others throughout a long working life.

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319 Jean Porter, *Moral Action and Christian Ethics* (Cambridge: Cambridge University Press, 1995).
320 Porter, 143.
321 Porter, 143.
322 Porter, 142.
323 MacIntyre gives examples from the novels of Jane Austen to illustrate this turning point, suddenly seeing things anew, especially in *Pride and Prejudice* (MacIntyre, 241).

Part 2. Pushing Pity Away

4.2.1 Introduction

In this second half of the chapter I wish to look more analytically at doctors' failings, focussing on their separation from patients, something which is in keeping with the pushing away of supererogatory responses. This is a defensive attitude which keeps moral obligations out of sight, and I have recognised such failings when patients have made complaints against me. The failings point to a neglect of those more human qualities which run alongside our technical competence. This is worth studying if we are to overcome self-regarding attitudes. By way of counterpoint, I begin this section with a study of Emmanuel Levinas because he shows what we owe each other fundamentally. Three varieties of failings are then described, all the more pointed in the light of what Levinas sets forth, and I claim that detachment from pity is at the root of this.

4.2.2 Emmanuel Levinas (1906-1995)

The works of Levinas are found in his publications, *Time and the Other* (1948), *Totality and Infinity* (1961), and *Otherwise than Being* (1974). His work is difficult to follow, though written in beautiful French prose with much complex imagery, and it has been described by Colin Davis as 'perhaps one of the boldest modern attempts to derail philosophy so that it can explore new territories'.[324] This leads me to expect that his work will support the idea that duty and supererogation can be 'flipped' as mentioned above. Levinas is not concerned with *ethics* but with the *ethical*, something more fundamental than moral decision making. We cannot put the ethical to one side; it is always with us, a presupposition of human life; for Levinas the ethical is inherent, preceding knowledge of the world and ontology. He is not concerned with normativity: he has a more detached stance, and refers to only one commandment, 'You shall not commit murder', and even this is something

[324] Colin Davis, *Levinas An Introduction* (Cambridge: Polity Press,1996), 144.

'fundamental but not founded' i.e., not appealing to reasons which we might find more or less persuasive.[325] Davis makes the point that,

> Levinas's ethics revolve around the possibility that I might encounter something which is radically other than myself. Western philosophy, Levinas suggests, has missed the encounter because it has always sought to appropriate the Other, to neutralize the threat it poses to the autonomy and sovereignty of the Same.[326]

This impossibility of grasping the Other is perhaps the fundamental basis of his philosophy. This echoes the failure of healing in *Mrs Dalloway,*[327] for what both Woolf and Levinas grasp is that moral engagement occurs in one-to-one interactions: that is where doctors should focus their attention, not on abstract moral theories nor on the generality of clinical 'cases'.

When we consider one-to-one interactions then there is a stark contrast between the examination of the face described by Levinas and the doctor's approach. A doctor might sense the emotional state of the patient at the start of the meeting and might then look more formally for signs of disease, e.g., thyroid disease can give the eyes a staring appearance. The doctor might examine the eyes with an ophthalmoscope, coming so close that the patient can feel the doctor's breath. Yet this proximity is not what concerns Levinas: the doctor is after all not seeking intimacy but is appropriating the patient, at least wanting to observe all the clinical signs of disease.[328] For all the supposed value of looking at people 'face-to-face', Levinas points out that it is impossible to do just that: 'we never see the "face" of the other, but only its "trace"'.[329] We can never see the 'wretchedness and suffering' of the other, for that is partly hidden by the patient, and perhaps not perceived by the doctor. The face

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325 'As a Christian, I want to say that "murder" or "suicide" marks when our perception should come to a halt. . . . . It is therefore a philosophical mistake to ask what is wrong with murder'. Hauerwas, 'Casuistry in Contest', in *The Hauerwas Reader,* 276.
This echoes Wittgenstein's comment in *Philosophical Investigations* (217): 'If I have exhausted the justifications , I have reached bedrock and my spade is turned. Then I am inclined to say: "This is simply what I do".'

326 Davis, 142.

327 'And why the devil he did it, Dr Holmes could not conceive' is the response to the suicide. Woolf, *Mrs Dalloway,*165.

328 'When one observes the colour of the eyes one is not in social relationship with the Other'. Davis, 133.

329 Hilary Putnam, 'Levinas and Judaism', in *The Cambridge Companion to Levinas,* ed. by Simon Critchley and Robert Bernasconi (Cambridge: Cambridge University Press, 2002), 45.

is not simply seen; it is not an intentional object. At this abstract level Levinas prefers the term '*visage',* which amounts to the recognition of an encounter with another; not occurring in the consciousness of the subject, rather in an inescapable alterity, akin to 'an epiphany or revelation'.[330] I suggested above that doctors try to appropriate their patients, which is an attempt to contain and control them, both in their Otherness and in their suffering.

A further obstacle to feeling the suffering of others is described by Levinas. In claiming the ineluctable alterity of the Other he points out that the Other must indeed remain just that; any grasping of the Other by the subject leads to the Other becoming incorporated into the subject. Levinas underscores this separation when he states that 'the failure of understanding is essential if the real otherness of the Other is to be preserved'.[331] This impossibility of grasping the suffering of the Other is a blow to the present-day advocacy of empathy: doctors' attempts at empathy lead to an appropriation of the Other, but *on the doctor's terms,* and any understanding of that suffering is always modulated and reduced by the process of trying to grasp it. I once consulted a doctor about a heart disturbance which alarmed me greatly, telling him about my symptoms and complaints. He then related back to me a summary of what he had heard, and although the information sounded factually correct yet he had captured nothing of the felt quality of my distress.[332]

Levinas claimed that it was a condition of birth that we were already indissolubly tied up with the ethical, and this accords with his view that we all have infinite responsibility for each other, including those who would torment and torture us. It is this asymmetry of the ethical relationship which is at the heart of his morality; he emphasises that if we think in terms of *quid pro quo* then we are not in the world of morality at all but in some calculative give and take where the weak go to the wall. We could say that ethics concerns us especially when others' interests conflict with our own. On the other hand the ethical is not something we can take up and put down; it is concerned with continually stretching beyond our reach, reminiscent of

330 Davis, 46.
331 Davis, 41.
332 I sense this is found in Christopher Hamilton's difficulties in describing the life of Maiti Girtanner who was tortured by a Gestapo officer who was also a medical doctor. Christopher Hamilton, 'Religion, Forgiveness and Humanity' in *Supererogation: Royal Institute of Philosophy Supplement: 77,* ed. by Christopher Cowley (Cambridge: Cambridge University Press, 2015), 185-205.

Wittgenstein's frustration at the limits of language. This belief that our obligations are boundless has been recently explored by James Mumford who describes the claims of Levinas and their strong rebuttal by Jean-Yves Lacoste.[333] Lacoste claimed that our encounters are mostly not the intense, one to one relationships which Levinas saw as primordial, but fleeting and *in medias res*. Mumford looked to the intensity of the Good Samaritan as demonstrating the fusion which can be achieved if we remember that Christ demonstrated both loving attention to others with the need for rest and repose.

Levinas focussed on the difference between the Saying and the Said as a means for us to get to the heart of his philosophy. By Said he refers to the structure of what is out there between us: propositional knowledge, evidence-based claims, all that is in the world. Traditional philosophy has its home in the Said, for proposal and response, logic and rhetoric all belong in the demonstrative world of the Said. With Saying it is different: 'Saying is more elusive because its meaning is precisely what cannot be encapsulated in the Said'; it is hard to pin down what Levinas means by this for the very attempt to do so forces the Saying to appear in the world of the Said, and that is just the problem!

We can sympathise with this position, for have we not all felt a mood strongly and yet been unable to capture its essence when asked to describe it: the precise aspect of the mood with its profundities and colourations is usually beyond our telling. The Said then seems to be an impoverished reduction of the Saying. Similarly it is a commonplace to say that much is lost when poems are translated, and I think this illustrates one aspect of what Levinas describes. He goes further than this however: for him it is not just about what is not said or cannot be said, or even the underlying attitude we bring to the Said. Levinas believed that our being is constituted by others, that is, in our acknowledgement and interaction with others. Perhaps a way of grasping this would be to think of the Said as a carapace or integument which we wear on going out into the world, masking the Saying as too vulnerable to be exposed.

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[333] James Mumford, 'The Experience of Obligation: The Enduring Promise of Levinas for Theological Ethics', *Studies in Christian Ethics,* 32 (3) (2019), 352-369. He explores the complex motivation of Oskar Schindler who rescued Jews by employing them in his factory in Krakow.

Needless to say, it is only in exposing ourselves, that is letting the Saying show itself, that true communication can begin. That is where our constitution is to be found.

Sincerity is at the heart of this:

> No Said equals the sincerity of Saying, is adequate to the veracity that is prior to the true, the veracity of the approach, of proximity, beyond presence. Sincerity would then be Saying with the Said.[334]

This seems to amount to a sincerity which precedes truth telling, and indeed which is the prerequisite for relationship, underlined by the *signifiance* of the Saying rather than the *signification* of the Said; the differing meanings of these French words pointing up the divergence between what is pointed at (signified) by the Said and what is hinted at (what is meaningful) in the Saying. A further point of interest is that the Saying and the Said exist side by side, as two aspects of life, continually interweaving and pulling apart. The diagrammatic picture of DNA comes to mind, with the two strands intimately coiled together, of equal importance. Both strands are necessary for life, just as the Saying and the Said are necessary for Being.

A parallel interweaving occurs between the subject and the object; and in the clinical setting we think of the patient as the object being questioned and examined by the subject-doctor. Catherine A. Racine, working in the setting of community mental health, here finds a complex, unequal interaction. At a familiar level we see the doctor as active before a passive patient, yet she shows how dynamic is the interaction. Levinas seeks to investigate that dynamism and to transcend the distinction; Racine is concerned with the 'seemingly intractable issue of how to "extricate" the "object" from the reductions of the "subject"'.[335] In this respect I would say that Levinas is concerned with what is taking place in the space between us.

Levinas was desirous of passing beyond the subject-object distinction, and his interpreters have indicated an interest in apophatic theology as a means of doing so. He was interested in going beyond the simple, face-to-face communication, towards

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334 Davis, 78.

335 Catherine A. Racine, *Beyond Clinical Dehumanisation Towards the Other in Community Mental Health Care: Levinas, Wonder and Autoethnography,* (London: Routledge; 2021), 142.

'something I speak to', an '"expression", "invocation", and "prayer"', and this is something which his advocates describe as difficult to grasp, something 'beyond being'.[336] As an example, a new patient came to see me and claimed, in passing, that she was 'allergic to water' and that her former GP had not paid any attention to her symptoms. This was nonsense from the biomedical point of view, but instead of enquiring further, and being pressed for time, I passed over it with mild acquiescence. Some months later she sent in a letter of complaint and left the practice. I wrongly believed that my facial expressions had been under my control, that I wore a professional mask, like an actor in a Noh drama,[337] whereas, according to Levinas, we continually mask and unmask ourselves *without knowing*: we are both 'judge and accused at once'.[338] I had seen her as a 'heart-sink' patient, while she perhaps had seen me as a representative of a profession which 'reduced' her into the category of 'a hard to help patient'. This is an example of the unawareness, both of how we are presenting ourselves and how we miss what is hanging between us, with unfortunate consequences for my patient, as with the tragic consequences for Septimus in *Mrs Dalloway.*

We might diagnose the doctors' failings towards Septimus in the light of Levinas: plenty of Said, but no attempt to catch any sense of the Saying, and with a condescension and paternalism indicating that the Saying was not worth their notice. This might be an injustice to Levinas whose philosophy is at an abstract, existential setting, but I think we can appropriate his ideas to clinical use,[339] and his ideas tip medical practice away from a scientific base in favour of an ethical practice.[340] Doctors and nurses might take notice of what is not said when relatives come to see patients, and for dying patients much effort is given to facilitating such expression. In such cases we are talking about secret or repressed feelings and knowledge, hinting at the tenderness and poignancy of relationship. Attentive listening seems to be the way forward here, a quality all the more touching to witness when shown by an

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336 Racine, 142.

337 the actors in Noh drama put on their masks before coming on stage; their emotions are indicated by their body language. By tilting their head up or down the stage lighting shows differing 'facial' expressions..

338 Bernhartd Waldenfels, *Cambridge Companion to Levinas,* 78.

339 A professor of philosophy complained to me that doctors were far too readily disposed to transfer philosophical ideas into medical practice, with a simplistic loss of context, detail, and complexity.

340 Michelle Clifton-Soderstrom, 'Levinas and the Patient as Other: The Ethical Foundation of Medicine', *Journal of Medicine and Philosophy,* 28 (2003), 447-460.

experienced doctor or nurse fully attentive to a patient when they form a dyadic 'bubble' separated off from the noise of a busy hospital ward. Such high quality listening encourages dying patients to communicate. This seems like a demonstration of what Mumford saw as the philosophy of Levinas in a public setting.

With regard to the infinite responsibility we have to each other, what can be said about supererogation in medicine? From this Levinasian perspective there is clearly no boundary between duty and supererogation, but I suggest that this open-ended responsibility seems to collapse before the queue of other patients waiting to be seen, the so-called 'hunger of the third party'.[341] We can see however that in the face-to-face meeting doctors might be said to have infinite responsibility: in finding the right diagnosis; in not dehumanizing the other; in taking the whole person into account, not just the presenting complaint. Doctors should be hesitant about taking patients at face value, for patients might be wary, needing time to make judgements about the doctor's openness and receptivity. In this respect the parting shot of 'and whilst I'm here doctor' might well unveil the patient's most concerning worry, and might require the consultation to start afresh. The best we can hope for is for doctors to remain alive to that sense of 'what more can be done'. Bernhard Waldenfels puts the case:

> The trace of the infinite which 'shines' as the face of the other shows the ambiguous feature of somebody before whom . . . I am responsible.[342]

That shine represents the aura of what more could be done, and it points us towards the supererogatory; at the very least it reminds us to be aware of what else might be going on in the space between us. That responsibility has been described by David Levin as 'primordial' and 'proto-moral', something inherent and inescapable.[343] Levin goes on to state that,

> the sense of obligation and responsibility [...] demands that we realize it in taking on a supererogatory responsibility that is possible only to the extent that we undergo a radical "sacrifice" of our ego-logical identity, subjecting its very existence to the welfare of the other.[344]

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341 Hilary Putnam, *Cambridge Companion to Levinas,* 37.
342 Waldenfels, *Cambridge Companion to Levinas,* 78.
343 David Michael Levin, *The Philosopher's Gaze: Modernity in the Shadow of Enlightenment* (Berkeley: University of California Press, 1999).
344 Levin, 240.

Another aspect of this is found in Levinas's belief that the 'ethical' is embodied in our flesh, and Levin comments further that,

> Thus, in a passivity prior to consciousness, prior to volition, prior to freedom, we are always already claimed by and for a supererogatory responsibility to and for the other; an obligation to and for the other has always already taken hold of us - through our very flesh.[345]

Levinas writes in a different register from other philosophers, although we might want to think of his work as too remote and speculative to have bearing on normative ethics. Nevertheless his ideas pose the biggest challenge to medical practice, for if accepted then our working practices and attitudes would all be subject to challenge: supererogation would already have grabbed hold of our flesh. In the next chapter, by way of illustration, I look at a doctor who seems to have felt a responsibility to his patients deep down in his flesh, and I follow the tragic consequences of his radical sacrifice.

It can be seen that a doctor responding to the philosophy of Levinas might be daunted or overcome by the requirements of infinite responsibility. This rarely takes place because of the defences we place before us, and I explore these in the next section.

4.2.3 The Defensive Stance

In this section I show that if Levinas knocks down the boundary between duty and supererogation, then some doctors will devote much time and energy to building that defensive wall, for without it we live troubled by the thought that *we have never done enough*. We might say that these doctors, in disregarding the Saying, spend much time in *not* getting to know their patients.

The stance was illustrated in the painting of *The Anatomy Lesson of Dr Tulp*, described in chapter 3, where the sense of professional *bravura* is shown; the surgeon does not focus on the cadaver but points to the dissected arm. The disengaged

345 Levin, 242.

professional stance is a principal ingredient of biomedicine, a defended state of mind. Patients need much more than that however. We notice how early the stance is adopted if we look at the bewilderment of medical students as to how to examine patients. Just as pre-clinical students do not know how to begin in the dissection room, so clinical students do not know how to examine a patient. The technique is not innate but the bewilderment is soon put aside once the medical student grasps the rudiments of how to do it.

An improbable comparison illustrates the difference between the untrained and the professional manner: the differences between Western and Japanese modes of painting have been described as the gap between perceptual and conceptual ways of seeing.[346] The traditional Western 'old master' painting is a perceptual way of seeing, while the few inky brush strokes of an Eastern graphic picture show a conceptual grasp where 'less is more', getting closer to the heart of the matter. Ruskin praised the 'facts' of a Western painting, just as anatomists point to the body in ever more painstaking detail, while critics of Eastern painting have praised the removal of 'descriptive accessories' in order to reveal 'the stark reality of its essence'.[347] Something akin to this is observable in medicine. We cannot know the person by simply accumulating facts, for example knowledge of physiology tells us nothing about feeling short of breath; both approaches are needed in practice. The detailed facts of anatomy are essential for surgery, e.g., the painstaking removal of a stone in the bile duct, yet the conceptual grasp is needed if we are to penetrate unexplored territory, e.g., the identification of mental health disorders such as PTSD (Post-Traumatic Stress Disorder).

Doctors who do not have access to both points of view are suffering from what I name 'attentive myopia'. I use this epithet as a catch-all for the state of looking and not seeing, hearing yet not listening, touching and not feeling. These are blunted states of awareness found in doctors who are swept along on the crest of rushing from one patient to another.[348] Although such doctors are attentive to what is under their noses,

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346 Owen E. Holloway, *Graphic Art of Japan: The Classical School* (London: Alec Tiranti, 1957), 27.

347 Holloway, 26-27.

348 Ward rounds are divided into 'teaching rounds' for the benefit of medical students, and 'business rounds' for the benefit of patients.

I am thinking of those uncurious attitudes and states of mind which leave us content to remain unaware of what is not on show.[349]

Attentive myopia is a state of short-sightedness. Eleonore Stump introduced the term 'cognitive hemianopia' to describe a parallel state of impairment.[350] She was keen to promote a 'humane turn' in philosophy, away from the primacy of analytical philosophy towards a more holistic approach. Her metaphor has been elaborated into discrimination between the two halves of the brain: the left hemisphere is associated with knowledge, the right hemisphere more with intuition (this is putting a complex study as briefly as could be; a full elaboration is found in the work of Iain McGilchrist).[351] She is concerned about the predominance of left hemisphere thinking. Clinical myopia might be cured by the prescription of concave lenses which allow us to see further, but patients with hemianopia usually have a more serious underlying condition. I am not sure if we can learn to acquire more intuitive awareness, but doctors with attentive myopia who refuse to seek help could be described as suffering from moral myopia, for help is available and it should be obtained: we need at least to become aware of those things of which we are unaware.[352] We can become aware of such deficiencies in ourselves by reading literature, and the novelist-philosopher Iris Murdoch, to be described in chapter 6, points the way to seeing ourselves clearly.[353]

In the next sections I describe how such states of unawareness manifest themselves, and they can be classified loosely into different categories. I name these categories: i) Pity and Pain; ii) 'Radical Aliens'; and iii) Intellectual Detachment. The author has

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349 'By opening our eyes we do not necessarily see what confronts us'. Iris Murdoch, 'The Sovereignty of Good over Other Concepts' in *The Sovereignty of Good* (London: Routledge,Great Minds: 2014), 82.

350 Eleonore Stump, *Wandering in Darkness: Narrative and the Problem of Suffering* (Oxford: Clarendon Press, 2010)

351 Visual impairments are neurologically complex; they include homonymous hemianopia, where the patient loses the right or left half of the visual field. A stroke is one cause of this disability which causes sufferers to bump into things which would normally be seen.
Iain McGilchrist, *The Master and his Emissary: The Divided Brain and the Making of the Western World* (New Haven: Yale University Press, 2012).

352 Doctors' annual appraisals include reflecting on what might have been done better - an invitation to see things anew.

353 'The good or even decent writer does not just 'imitate doctors' talk', but attempts to understand and portray the doctors' 'world', and these pictures, however modest, of other 'worlds' are interesting and valuable'. Iris Murdoch, *The Fire and the Sun* (Oxford: Oxford University Press, 1978), 85-86.

noted elements of these categories in himself, especially at times of high pressure and stress.

4.2.4 Pity and Pain

Let us look at how we approach the patient in pain. Commenting on scepticism in his reading of Wittgenstein, Saul Kripke writes:

> The correct interpretation of our normal discourse involves a certain inversion: we do not pity others because we attribute pain to them, we attribute pain to them because we pity them. (More exactly: our attitude is revealed to be an attitude toward other minds in virtue of our pity and related attitudes.) [354]

Earlier in the text is a study entitled, 'Feigning pain' which looks at the question of whether or not criteria need to be satisfied before we accept that someone is in pain. Kripke's comments suggest how inverted much of medicine has become. A dental example illustrates this: a patient is given an anaesthetic injection; the procedure begins but the patient jumps with pain; the impatient dentist thinks the injection should have worked by now, does not pity the patient and so does not attribute pain to him; a supplementary injection might be given with a bad grace. It should in fact be the other way round: the dentist should pity all patients in distress as the foundation of his work. More rightly, the dentist then accepts the patient is still in pain despite the injection; the failure of anaesthesia does not irritate him but moves him to more pity, and so a second injection is given with good grace. The patient is reassured, thus lowering the response to pain and making things more bearable. Kripke's approach puts the dentist in the right attitude, trusting the patient and preferring to doubt his own placing of the injection rather than the patient.

By pitying patients *from the outset* we join in their suffering and become more imaginative in finding a remedy for their pain. A more homely example occurs when we hurt our loved ones. We might be dulled to their pain, a dullness caused by self-righteousness, but then we suddenly become alive to their pain when our pity returns

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354 Saul Kripke, in Simon Glendinning, *On Being With Others, Heidegger - Derrida - Wittgenstein* (London: Routledge, 1998), 152.

on some familiar turn of the head or a gesture which moves us to pity despite our anger and pride.[355]

4.2.5 'Radical Aliens'

A second mechanism of failure of perception is more metaphysical in tone. The passage on 'feigning pain' comes in Simon Glendinning's book, *On Being With Others*, a study of the scepticism of other minds.[356] Criteria are described by Glendinning as being less concerned with what things *are*, rather in *what* things are, i.e., more concerned with identity rather than existence. So when we see patients grimacing we ordinarily ascribe pain to them; on those rare occasions when doubt enters our mind we do not say that the criteria have not been met, rather we say that the satisfaction of criteria is beside the point. Glendinning uses the phrase, 'one is altogether lost for words',[357] and here the doctor is outside the familiar world and is left thinking the patient's behaviour is outside of what can be known. The text continues,

> The behavioural occurrence or happening is unintelligible. And hence, on the approach I am defending, one does not perceive the soul of a living thing. A radically extreme case in which 'no criteria are satisfied' would be one in which the behaviour of a living thing is not part of a life-textile in which one is remotely at home. Living things of this kind are what one might call 'radical aliens'.[358]

The danger is that if patients do not meet the criteria then they are at risk of being marginalised. An example is seen in footage of film from the First World War: soldiers suffering from 'shell-shock' displayed bizarre and peculiar gaits which were not like those caused by recognised neurological diseases. Existing criteria were not satisfied, so some doctors thought these men must be dissembling (they were clearly not part of any known 'life-textile'). It was a measure of the originality of doctors

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355 'Thus their hearts' bond began, in due time signed, | And long years hence, when Age had scared Romance, | At some old attitude of his or glance | That gallery-scene would break upon her mind, | With him as minstrel, ardent, young, and trim, | Bowing "New Sabbath" or "Mount Ephraim".' From *A Church Romance* by Thomas Hardy.

356 Glendinning, 152.

357 Glendinning, 145.

358 Glendinning, 145.

such as Dr Rivers, to be described in chapter 8, that such new categories of suffering were identified and that these patients were not dismissed as cowards.

Such mechanisms might explain what is taking place when doctors behave with cruelty. Patients at risk are those with whom the doctor is not 'remotely at home', resulting in their falling into a sub-human category. The telling phrase is, 'one does not perceive the soul of a living thing'. What might be done to protect patients from falling into sub-human categories? Glendinning points out that the satisfaction of criteria does not 'determine the certainty of statements or knowledge or some circumstance'.[359] Criteria are double-edged; they are both an aid to diagnosis and a rationale for excluding persons from the human community. I suggest that being alive to pity, which we can also call compassion (for in this thesis I do not distinguish between these states, *pace* the work of scholars to refine our understanding), is the best antidote to such exclusions.[360] I look at ways to make ourselves alive to pity in chapter 8, though professionally it might be an uphill struggle.[361]

4.2.6 Intellectual Detachment

A third form of alienation is illustrated in the Sherlock Holmes novels by Arthur Conan Doyle. Dr Watson provides the medical leitmotif and acts as a foil to brilliant displays of rationality which lead logically to solving the crime. What we might now term the 'emotional intelligence' of Dr Watson is a counterbalance to the dispassionate views of Holmes. Without that counterbalance Holmes's over-developed rationality would be worrying; indeed Watson often spots the clues which Holmes then interprets.

Conan Doyle studied medicine at Edinburgh University where inspiration for the character of Sherlock Holmes was provided by Dr Joseph Bell (1837-1911). He had impressive powers of observation, inference and deduction, of great use in his

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359 Glendinning, 145.

360 David E. Cartwright, 'Schopenhauer's Compassion and Nietzsche's Pity', *Schopenhauer Jahrbuch,* 69:(1988) 557-567.

361 Arthur Kleinmann attributes to Bruno Latour a subtle form of discounting, so-called 'Pasteurization', reducing it to a more palatable distress, at least from the doctor's point of view. Arthur Kleinmann, *Writing at the Margin, Discourse between Anthropology and Medicine* (Berkeley: University of California Press, 1995), 276.

speciality of forensic pathology, but the concern is when such powers are uncritically applied to the living. This approach can be seen when so-called 'spot diagnosis' becomes an exercise in which medical students indulge while looking at passers-by on the street. It seems to provide a privileged point of view, and can lead to disengagement from patients when medical diagnoses supersede ordinary courtesies.[362]

I find at the core of these attitudinal failings a detachment from pity. Doctors can shield themselves from the pathos of patients by focussing on the investigation and treatment of disease, applying themselves vigorously and with a good end in sight, but when this is taken to an extreme then professional duties lose their anchor in moral obligations. There is danger in this.[363] I see the need for compassion, as with the dentist, as a moral obligation; curiosity can be seen as a professional substitute which might lead to the better treatment of disease but can transform compassion into egoism. I suggest Sir William Bradshaw might be taken as an illustration of that regrettable transformation.

What unites these three forms of alienation is a shift away from the patient as person towards a self-centred view on the part of the doctor. If we think of the locus of attention continually moving back and forth from self to other in ordinary encounters, then these three forms of alienation keep the locus of attention firmly within the doctor, not extending outwards towards the other. They are therefore antagonistic towards that movement towards the other which characterises supererogation.

4.2.7 Conclusion

In this chapter I have made a detailed study of one novel, *Mrs Dalloway*, in order to point out the failings of doctors as perceived by Virginia Woolf. These failings are

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362 Max Scheler describes how blushing can be explained in terms of changes in the blood vessels while ignoring the embarrassment which provokes it. Max Scheler, *The Nature of Sympathy,* trans. by Peter Heath (London: Routledge & Kegan Paul Ltd, 1954), 262. Thomas Hardy gives a touching account of blushing in *Far From the Madding Crowd,* chapter 8, where the timidity of Joseph Poorgrass is kindly discussed over a mug of cider.

363 Paul Guyer, 'Schopenhauer, Kant and Compassion', *Kantian Review,* 17 (2012), 403-429. Christopher Janaway, *Schopenhauer: A Very Short Introduction,* (Oxford: Oxford University Press, 2002), 96-99. Schopenhauer noted how compassion can be deflected into curiosity.

not uncommon; indeed some doctors would not see anything wrong with this behaviour. I would suggest that such doctors are dysfunctional and lop-sided. I put this down to failures of communication, along with a lack of imagination by doctors in grasping the suffering of patients. Professional duty has pushed moral obligations to one side, leaving duty as something inflated and self-regarding. I have included Levinas in this chapter as an indication of how such failings can be overcome so that duty and moral obligation might be more firmly glued together. His philosophy points to an open-ended responsibility to patients, and it must be said that some doctors have adopted defensive postures to spare themselves from such exhaustion. The dysfunction seems to be caused by a detachment from pity. I suggest the remedy is for doctors to stand alongside their patients and not to try to elevate themselves above their suffering. In the next chapter a new model of supererogation is proposed, based upon just this quality of giving of oneself and of standing alongside the patient, even at cost to oneself.

5. Chapter Five: Supererogation as Sacrifice: A New Interim Model

5.1 Introduction

In Chapter 1 we looked at the Beyond Duty model and found it to be unsatisfactory. It is suited to the modest 'oversubscription' examples illustrated by the janitor doing unpaid overtime, but it cannot encompass the actions of the 'heroic doctor' who goes to a plague-ridden city. In chapters 2 and 3 we looked at the history of supererogation and how it interacts with the obligations arising from professionalization. In chapter 4 we looked at how doctors are portrayed in novels, giving us insight into how they distance themselves from patients. In this chapter we start to see how doctors should see patients *rightly*. We explore a new model, and I illustrate it in the life of Dr Noel Chavasse, a First World War hero. Unlike the doctors in *Mrs Dalloway* he was wholly engaged with his patients. It might be thought that supererogation in medicine consists of larger-than-life doctors in difficult situations, with heroism as the cardinal feature. I look at this idea to see how well supererogation can be placed on this foundation.

Here also is proposed a new view of supererogation, turning it from the traditional, vertical view of a column of duty with supererogatory acts perched on top, to a horizontal view in which dutiful and supererogatory acts are mixed together without a sense of hierarchy.

I introduce the ring of Gyges as a philosophical device to distinguish between intention and motivation. I claim that these both need to be in accord if we are to understand supererogation arising from a foundation of generosity; indeed the virtue of generosity is spoilt or vitiated if the intention is good but the motivation is bad.

5.2 Heroic Medicine

Heroic medicine might be defined as the voluntary self-exposure by doctors to risks which are far beyond the ordinary. Médecins sans Frontières, founded in 1971 after

the Biafra secession, operates in countries where conditions are often dangerous. The element of supererogation seems to lie in the volunteering in the first place, for once on site then a sense of obligation takes over, the familiar falling back from supererogation into the category of duty. We saw this with the attendance at a road traffic accident described in chapter 1: moral obligation catches us in its nets and draws us in; professionally we cannot then walk away.

Heroic medicine is characterised by putting ourselves at risk for the benefit of patients. John Hunter (1728-1793) the anatomist and surgeon, is said to have infected himself with venereal disease in order to distinguish syphilis from gonorrhoea. The nineteenth century Munich hygienist, Max von Pettenkofer, drank from a flask containing cholera germs sent to him by rival Robert Koch.[364] He remained free from infection, thus claiming to overthrow Koch's theories. In Edinburgh John Scott Haldane (1860-1936) became a leading physiologist and researcher into occupational diseases, and his son, John Burdon Sanderson Haldane (1892-1964), also did important work in genetics. Both experimented upon themselves as test-subjects and suffered injuries as a result. The son drank hydrochloric acid and inhaled high concentrations of carbon dioxide, also subjecting himself to decompression in an air chamber form which he emerged with a perforated ear drum and a crushed vertebra,[365]

With such zeal for self-experimentation we can label these doctors heroic because they disregarded their own safety in the interest of others. A subtle concern enters into our appraisal when we question for whose benefit these experiments were undertaken: a suspicion of self-referential reputation building cannot be excluded, and that tends to vitiate the criterion of doing good for others.[366] Despite this reservation, it does seem that heroic service to others which puts the agent at risk might well be synonymous with supererogation. I now look at a doctor who exemplifies this approach.

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364 Porter, 437.

365 https://en.wikipedia.org.wiki: J B S Haldane [accessed 28 May 2023]

366 Heyd states that doing good to others is a criterion of supererogation (Heyd, 115). This is disputed by Mark Wynn, 'Supererogation and the relationship between religious and secular ethics: some perspective drawn from Thomas Aquinas and John of the Cross', *Royal Institute of Philosophy Supplement 77,* ed. by Christopher Cowley (Cambridge: Cambridge University Press, 2015), 167-168.

5.3 Noel Chavasse (1884-1917) RAMC, MC, VC and bar

In Liverpool Cathedral there is a memorial to Noel Chavasse, a doctor in the Royal Army Medical Corps who certainly stood apart. I undertake a detailed look at him. He earned the VC twice: the first time in 1916 for attending wounded men 'in the open all day, under heavy fire, frequently in view of the enemy';[367] again in 1917, when wounded himself, he continued to go out and find wounded men to bring them back to safety. He died of his wounds, and it is possible that if he had permitted himself to be attended soon after being injured then he might have survived. He was the only man in the First World War to earn the VC twice, as well as the Military Cross. There are only two other recipients who have been awarded the VC twice; one of these was also a doctor.[368]

Let us think once more of the murals at St Bartholomew's Hospital in London: Christ at the Pool of Bethesda corresponds to the healing of the sick which doctors are ordinarily engaged in, but the Good Samaritan has a different flavour. By slowing down on the road to give aid, the Good Samaritan actually increased his own vulnerability, like a ship which falls behind the convoy. We think of the Good Samaritan as travelling alone, yet by choosing to fall behind he stood apart from other travellers. We can view Chavasse from the point of view of a side-shoot breaking away from the main stem, or of a bird at the edge of the flock.

Captain Chavasse, acting as a Good Samaritan, is exalted in our eyes, yet he did not exalt himself. He claimed that he was only doing his duty after all, even if others might not have interpreted things so. Rather, the evidence here, I suggest, is of Captain Chavasse and the Good Samaritan simply doing *what needed to be done*. This is the central cleft of the concept of supererogation, the division between doing our duty versus doing what needs to be done. Fortunately they often coincide, yet when they do not then conceptual tensions arise, and they perhaps equate to the deontic and axiological views of morality proposed by Heyd.[369] As described in

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367 Ann Clayton, *Chavasse-Double VC* (London: Leo Cooper, 1992), 165.

368 Dr Arthur Martin-Leake (1874-1953) also rescued wounded men under fire on two occasions; though injured himself during one rescue, he refused water until all the other men had received assistance.

369 Heyd, 49-51.

Chapter 1, soon after the publication of Urmson's essay, Feinberg pointed out a problem in seeing moral obligations as being too readily understandable in legal terms, in so-called 'house rules'.[370] We can see at once a difference: the vertical, 'column' view implies self-denial in imitation of Christ's suffering on the cross; this horizontal view which I am now discussing eschews a sense of exaltation, and sees supererogation as pulling others out of danger and disregarding our own increased vulnerability. In this respect Chavasse seems not to have distinguished between precepts and counsels; indeed his virtue reformulated them into a new whole.

5.4 Motivation and Intention

I am here trying to disentangle motivation and intention because this is important for an understanding of the moral psychology of supererogation. Heyd distinguishes between them: 'While intention forms part of the description of an act, the motive is only the "feeling" which moves us to do it.' He goes on to say that, 'Although the *motives* of supererogatory acts may be self-regarding, the *intention* must be other-regarding'.[371] This distinction is not, I suggest, so straightforward in practice. Let us imagine an onlooker of Captain Chavasse, another doctor in the regiment, making a more mainstream interpretation of the situation:

> *Any number of men wounded, all requiring attention, the enemy still firing, and there goes Chavasse over the top. That's all very well, but who is to attend to the men back here. Desperate injuries, many in a very bad state, the transports haven't come, and with him over there and pinned down in the fox-holes I'd better stay here and hold the fort.*

Note, there's nothing wrong with the sentiments of the second doctor, and we can understand his irritation that ordinary work is being left to him while Chavasse is exposing himself to danger *again*. The second doctor is performing his work, so is Chavasse; nor should we say that Chavasse is doing a greater duty than his colleague, for the ordinary work goes on. Both men could claim that they were doing what

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370 Feinberg, 3-24. He distinguished between what we *ought* to do independently of the obligations and duties of our employment. The latter can be know by looking up our contractual duties or by 'asking the boss', but the former demands more from the agent than can be specified in advance.

371 Heyd, 137. He derives the distinction from John Stuart Mill.

needed to be done, it is just that two interpretations are in play. Let us extend this further: let us imagine that the colleague thinks that they have enough wounded to attend to without seeking more, and that they are likely to help more men by staying put than by going over the top to bring back yet more wounded.[372]

Let us now imagine another doctor, a third doctor who strongly desires a VC, deliberately going over the top during the next battle, searching for wounded men in imitation of Chavasse. This third doctor is not behaving rightly; he would be seeing the injured men merely as a means and not as an end in themselves. Where decisions have to be made in such little time then we fall back onto those habits and dispositions modelled by the virtues. In this respect supererogatory actions, all over in a moment, are the fruits of the modelling of character which has taken place over years of upbringing. That is what sustains us when we have no time to think.[373] The third doctor displays the vice of vainglory, a vice condemned by Aquinas.[374] He might succeed in saving the lives of injured men, but his actions would exemplify a fortitude gone wild, a reckless courage which has broken free from the reins of prudence. If we are to emerge from desperate situations then prudence should be our lead with the other virtues entrained behind.[375] In support of this view is the description of Aquinas that prudence was the 'charioteer' of the other cardinal virtues.[376] I believe this shows that supererogatory acts, such as putting oneself at grave risk for the sake of others, can be spoilt if the intention is not supported by good motivation.

For Aquinas three criteria had to be met in judging the moral goodness of an act: the act has to be morally good in itself; it has be done with a good intention; it has to be right in the circumstances.[377] The vainglorious doctor would violate at least one of these criteria, for the rescue would have revealed a bad intention, and might not have been right in the circumstances. In this light also, we see that Chavasse met all three

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372 Utilitarian cost/benefit analyses seem respectable, especially when resources are limited and whole populations are involved, yet moral theories do not take into account the psychological forces which send us down particular pathways in the first place.

373 Urmson's essay give an example of the soldier who throws himself on a grenade in order to save his colleagues.

374 ST, 1-11, Q19, Art7, Ad2.

375 Pieper, 124-125.

376 'Over and above the three 'moral' virtues stands 'prudence', their 'charioteer'; the one intellectual virtue of the cardinal four.' Kirk, 387.

377 Stephen J. Pope, 'Overview of the Ethics of Thomas Aquinas', in *The Ethics of Aquinas,* ed. by Stephen J. Pope (Washington D.C.: Georgetown University Press, 2002), 30-53, p.33.

criteria: his act was morally good; it enacted a good intention; it was 'done in a way that is morally appropriate given the circumstances'. In the desperate conditions of the battlefield Chavasse's exposure to danger was appropriate, as with the doctors who contracted diphtheria described in chapter 1, for even when stripped of the usual accoutrements of a clinical setting, doctors can still act to suit the circumstances, including the exposure of oneself to enemy fire.

What about the habits and dispositions of Chavasse? We know that he came from a clerical family: his father was Bishop of Liverpool who later founded St Peter's Hall (now College) in Oxford. Chavasse's three brothers also served in the war, his eldest brother winning the Military Cross and becoming Bishop of Rochester, while another brother won the Military Cross and became a surgeon. That background gives a favourable setting for the acquisition of the virtues, shown both in his courage and in modest actions too, such as contriving to keep a dairy cow near the Front so that milk could be provided for his convalescent patients. I see this as a touching example of brotherly love, or *philia*, for the wounded.

It seems to me that Chavasse exemplifies an attitude which was publicly lauded in the First World War, found hollow by some of the war poets, and excoriated half a century later.[378] I am thinking of the 'muscular Christianity' of the public schools, the call of nobility of character, of what England 'expects' for King and Country.[379] I think a man from this background, having a sense of what was required and a sense of autonomy, would look down on any list of what was required *from* him; he would have a much better idea *for himself* of what was called for. We might call that part of an 'enacted dramatic narrative'.[380] Putting aside any questions of pride and insubordination to authority, we value, as Swinburne says, an inclination to do the

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[378] I am thinking of 'Oh! What a Lovely War!' the 1969 film directed by Richard Attenborough

[379] Similar attitudes and behaviours, perhaps less exalted but just as noble, are displayed by modern soldiers in action.

[380] This is not a sign of arrogance, rather it corresponds to the interplay of character, self-interpretation and narrative cohesion identified by MacIntyre and analysed further by Paul Kelly. Chavasse felt at home in the RAMC and Scots Guards, his service to others a culmination of his life narrative. Alasdair MacIntyre, *After Virtue* (London: Duckworth & Co, 2006), 215-217. Paul Kelly, 'MacIntyre's Critique of Utilitarianism' in *After MacIntyre, Critical Perpectives on the Work of Alasdair MacIntyre,* ed. by John Horton and Susan Mendus (Cambridge: Polity Press, 1994), 134.

good which we can see *for ourselves*,[381] and this is echoed by Jean Porter who gives an account of how the virtues are acquired in childhood and brought to fruition in adult life. Referring to the virtues, Porter emphasises how a person brought up in a virtuous way comes to the stage where 'she can see for herself what would be involved in acting in accordance with them'.[382] This we see in Chavasse, for he had so fully internalised his duties that they were part of him; we might prefer to say that he had transcended his duties, though his speech was still infused with the sense of duty we would expect from a soldier.[383] In his last letter, dictated to the nurse attending him, he wrote to the woman he loved, 'Give her my love, tell her Duty called and called me to obey'.[384]

What he called duty, we might call virtue: he was so virtuous that he transcended duty. In this respect he left duties behind and was concerned with 'being' rather than 'doing'. This emphasis on virtue stems from Aquinas, described by Pope as something 'more fundamental than either external acts, the moral laws by which they are judged, or particular choices determining behaviour in concrete cases', and this indicates that duty, at least as judged by external acts, is surpassed by virtue.[385] I here imagine that Chavasse felt violated by the injuries done to others. He could be likened to a bird on the edge of the flock with a better view of what was taking place on the ground, for that bird has an uninterrupted vision and an elemental responsiveness.

Such people as Chavasse are not constrained by duty; they take it in their stride and step beyond it in good measure. Nor do they climb the ladder to Heaven by self-denial; rather they *traverse* around duty, taking a broad view and finding their own way forward. More fittingly, we might say such people have an all-consuming sense of virtue with a wide lateral thrust. Another example was Edith Cavell (1865-1915), who nursed injured soldiers, allied and enemy, during the First World War, helping

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381 'And finally we value the agent who is naturally inclined to do the good as *he* sees it, who has a strong desire for the good as such, . . ., the agent with the naturally "holy will".' Swinburne, 28.

382 Jean Porter, *Moral Action and Christian Ethics* (Cambridge: Cambridge University Press, 1995), 174-177. where principled pacifism might display as courageous a stance as military action.

383 Mark Wynn writes, 'the awakened person's relation to God is one of love', and 'the notion of obligation has no application' to such a person. Wynn, 177.

384 Clayton, 207.

385 Pope, 33.

them cross the frontier into neutral Holland. She was charged with treason by the German authorities and was executed. Other remarkable examples are recorded.[386]

5.5 Objections to vertical clefts

I have pictured the Beyond Duty model as a column with precepts making up the length of the column and with counsels perched on top. In this second model I have turned that column onto its side, with a view of duty and supererogation as existing side by side, though divided by vertical clefts. I am here trying to see duty and supererogation as being side by side, indeed contiguous. It might be objected that the notion of vertical clefts between us, representing a new view of supererogation, is merely a sleight of hand, and that an altered point of view does not amount to a different category. It might also be said that the examples above, representing that peculiar period of the First World War, are all so charged with decades of our sedimented responses that we should be cautious not to confuse an emotional responsiveness with a cool attempt to change the time-honoured view of supererogation. The heroic nobility of Chavasse might simply amount to the expression, in a war of the twentieth century, of a desire for the self-sacrifice displayed by religious ascetics of mediaeval Europe. For the mediaeval mind service for the benefit of the souls of others was just as important to them as the rush to rescue the injured victims of war is to us.

I claim here that Chavasse's actions were part and parcel of his daily life, and that what we see as extraordinary was mundane for him, in the phenomenological sense of the texture of a life which was wide and inclusive. He was not chasing after distinction for its own sake, but as part of the fabric of his life cut from the broadcloth of his upbringing. To see his actions as over and beyond the call of duty would thus be incoherent from his point of view. He did not seek self-sacrifice, but it came upon him while doing his ordinary work in as virtuous a way as possible.

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386 Dr Elsie Maud Inglis trained as one of the first women doctors in Edinburgh. She set up hospitals run by women for injured soldiers. She was awarded the Order of the White Eagle by the Crown Prince of Serbia. In civilian practice she often waived her fees and paid for convalescence for poor patients. Nurse Nellie Spindler of St James Hospital, Leeds, died in 1917, killed by the explosion of a shell while attending to the wounded at a hospital near Ypres. She is the only woman buried amongst 10,000 men at Lijssenthoek Military Cemetery in Belgium.

One keeps returning to the image of Chavasse disregarding his own wounds while attending to the injured. This indicates a dissolution of the boundary between duty and supererogation, at least *in foro interno*. We can think of the breakdown of the Beyond Duty model caused by the chaos of war, and although we lack sufficient detail to understand his motivation, Chavasse had been brought up on a diet of what Wynn calls, 'theological goods'.[387] He did not seek to separate himself from the wounded men, nor did he see himself as in a superior category, as might be found in the Beyond Duty model. After obtaining his first VC he declined a posting to the safety of a hospital near the French coast, even though that would have given him more scope to practise the orthopaedic surgery which interested him: he preferred to stay with his men. He was an example of the 'spiritual adept' who finds no 'ready application' in the distinction between duty and supererogation; duty is no longer experienced 'as a constraint or as binding'.[388] I propose that Chavasse should be seen as an exemplar in this light. I think further that if he had lingered in the field of fire, not from a sense of vainglory or bravado, as the third doctor might have done, but all the better to rescue more wounded, then that would have transcended duty; that was simply what needed to be done, and his personal safety was somehow out of the picture. It is of note that he disdained the bullets flying around him while attending to the wounded. This suggests an identification with the men he was attending, comforting them by his attitude to danger as much as by the surgical techniques he brought to bear in the foxholes. With this in mind, I think it is not too fanciful to see him as illustrating the seamless fusion of the man and the doctor which I find in such exemplars, a view in opposition to the belief of Heyd.

Putting our own safety out of the picture indicates a cardinal feature of supererogation: making ourselves vulnerable and sharing in the vulnerability of those we are helping. This seems paradoxical, for we need to be strong to help others. Something of this quality is shown in the Sermon on the Mount (Matthew, 5-7), the limpid beauty of purity of heart, of meekness and of loving others, including our enemies. Just before and after the Sermon Christ heals the sick, and this brings to mind the loving attention Chavasse brought to the wounded. His actions were heroic,

387 Wynn, 172-174.
388 Wynn, 177.

yet waiting until the others had received medical attention, though wounded himself, crosses a boundary into *kenosis*, going beyond the giving of oneself into an active emptying of oneself. While there is now much discussion about the nature of kenosis,[389] I put forward another variant, something we could call *physiological kenosis*. Chavasse must have known that his blood and bodily fluids were becoming depleted, that dangerous infection would be taking hold, especially in his abdominal wound. That forbearance seems even more moving than his active exposure to fire, for in the field hospital he would have had time to reflect, and by letting others go first he increased their chances at the cost of his own. Thus he demonstrated both *agape*, the love of others which transcends our bodily limitations, and so-called 'power in vulnerability'. Put epigrammatically, he emptied himself of his humanity in order to replenish the humanity of others.

5.6 The Second Doctor and Regret

In order to clarify the distinction between intention and motivation, which might appear unclear, let us now look at the responses of the second doctor mentioned above. Many of Chavasse's medical colleagues attended his funeral. What was going on in them? Might not the second doctor have wished that he had behaved differently, had discarded his usual carefulness and gone over the parapet with Chavasse? His carefulness now seemed more like timidity, and he reproached himself for that, but was his regret focussed on the sufferings of others or on his failure to seize a chance to shine?[390] Furthermore we must not forget the important distinction between the *spectacular* and the *heroic.* These often coincide but can diverge profoundly. Kirk points out, using a military example, that the soldier who excels in the field is spectacular, but his colleague at the training camp, miles from danger, might 'be breaking his heart because duty prevents his going to the front'.[391] Thus the soldier not exposed to danger might be acting heroically by keeping his aching regret in check, just as much as his dashing colleague at the front. The

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389 Sarah Coakley, 'Kenosis and Subversion' in *Powers and Submissions: Spirituality, Philosophy and Gender* (Oxford: Blackwell, 2002). Coakley identifies six different species or strains of kenosis.

390 Robert Graves describes Siegfried Sassoon, in hospital at Craiglockhart during the war: 'Siegfried felt he would rather be anywhere than in hospital; he couldn't bear to think of poor Old Joe lying out all night in shell-holes and being shelled.' Robert Graves, *Goodbye to All That* (Harmondsworth: Penguin, 1976), 225.

391 Kirk, 519.

spectacular is apparent to all, but the heroic might well be hidden from view. Covert heroism is shown particularly in the forbearance from being rescued in order to support others.[392] We need to know what motivates these three different doctors, Dr Chavasse and the two imaginary doctors I have described. How can we perceive motivation when things happen so quickly on the spur of the moment?

5.7 The Ring of Gyges

Let us imagine that we have special vision, that we can see the motivation and intention of actors better than the actors themselves. I propose that we take recourse to the ring of Gyges, allowing us to perceive motivation more clearly and to distinguish autonomous from heteronomous actions. I am hoping to show that motivation, not just intention, is important in appraising supererogatory acts: if motivation is self-regarding then intention, no matter how strongly inclined to the service of others, is weakened.

The ring is the most ancient of philosophical devices, found in book 2 of Plato's *Republic.*[393] Wearing the ring renders us invisible to others, thus helping to fulfil our heart's desire when our actions are not apparent to the appraisal of others. By turning the bezel on the ring and becoming invisible our motives become salient to ourselves, uncontaminated by the usual reflectivity of ourselves in the eyes of others. In Plato's account the ring is used to demonstrate the difference between the virtue of justice versus the mere utility of appearing to be just. The ring was brought back to life by Bernard Williams who was especially interested in the role of autonomy, and he asks just how far we should trust ourselves in pursuit of what we have decided is the good.[394] In the enquiring spirit of Williams, I propose the liberty of extending the powers of the ring yet further to see if we can compare and contrast motivation and intention.[395]

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392 Janusz Korczak, a Polish doctor who was director of an orphanage when the Warsaw ghetto was cleared in 1942. He was offered escape for himself from deportation to Treblinka by a Nazi officer, but Korczak stayed with the children and accompanied them to the camp. None survived.

393 Plato, *The Republic of Plato,* trans. by Francis MacDonald Cornforth (Oxford: Clarendon Press, 1955).

394 Bernard Williams, *Shame and Necessity*, 98-102.

395 And Plato does allow us to 'suppose that there were two such magic rings'. Plato, p.44.

Let us provide Chavasse with the ring just before going over the parapet, for the invisibility would lessen his chances of being hit, at least by a sniper. But let us go further with this experiment and imagine that not just our bodies but our intentions are hidden from view. Plato imagines the 'perfectly unjust man' suddenly gaining 'a perfect reputation for justice'; and then let us imagine another man, who is in fact perfectly just, suddenly acquiring an unshakeable reputation for injustice.[396] Let us imagine Chavasse being given a reputation for cowardice, the quality most in opposition to the qualities which earned him the VC, and let the second doctor, now also wearing a ring, becoming overnight the talk of the regiment for his bravery. In fact such a volte-face does not seem impossible in the chaos of war.[397]

Williams writes about the Guardians, that class of society in Plato's *Republic,* perhaps most aptly compared with the elite of Victorian and Edwardian society from which Chavasse came. Williams sets this class apart as possessing an 'internalised other', which he describes as 'a paradigm of justice gained from their intellectual formation'.[398] Chavasse would have acted on that sense of justice, though we can imagine the torment he would have faced when, desirous of going over the top, he had then been falsely judged to be lacking in bravery by his commanding officer who would have told him to stay back, letting some other doctor go forward. Would his autonomy have led to his disobeying orders?

These philosophical experiments start to unravel if indulged in to excess. However, Williams cautiously takes us one stage further, and in 'an exercise of ethical Cartesianism'[399] lets us imagine the just man, but now, because of our devices, falsely thought to be unjust, and asks how far this truly just man would go in his autonomous judgement of right from wrong. Williams hopes that if this truly just man persisted acting contrary to the judgement of others then he would eventually take some notice of that, for one would have difficulty deciding if he were 'a solitary bearer of true

396 Williams, 98.
397 Robert Graves describes how he and his men were stranded in a forward position, at the mercy of enemy fire, yet managed to stay out of sight until rescued the following morning. Reputations for false heroism and for false cowardice could flare up and die down in an instant.
398 Williams, *Shame and Necessity,* 99.
399 Williams, 99.

justice or a deluded crank'.[400] From the agent's point of view there must be severe tension, at least we would hope there would be tension, within him: obedience towards the commanding officer holding him back, versus a sense of intense desire to attend the wounded driving him forward.

How would the second doctor fare in this thought experiment? I have been careful to portray him as doing his duty; no failure is imputed to him, and yet our experiment has transformed his reputation into one of outstanding bravery. How would that affect his performance? What might have encouraged him to go over the parapet when he preferred to look after the wounded already to hand? The difference is a stark contrast between professional duty and moral obligation; how far such a division results from what is heteronomous and from what arises from within. A direct order from his commanding officer to go and attend to the wounded in the foxholes would be heteronomous, and an immediate response without delay would have been appropriate in the field.[401] Similarly if the commanding officer had said, 'I know you are the bravest man on the front but I need you to stay back here', then that would have brought the comfort of his new-found reputation for bravery *not* being put to the test, with relief that his innate carefulness need not dress itself up in heroic postures. The difficulty would have been sharpest if the commanding officer, himself not sure what to do, left it to the judgement of the doctor: 'You know where you can best be deployed, I'll leave it to you. We'll give you all the cover we can muster if you want to have a go'.[402] The doctor's torment would have been of letting go of some of his patients in order to reach others.[403]

Supererogation is optional, and no blame attaches if such opportunities are passed over, yet the doctor would have found the choice stark, difficult and revealing. Chavasse would have faced Hobson's choice: he simply had to go and help the men, and his new-found reputation of being timid, which the ring had given him, would not

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400 Williams, 99. Also, the 2017 film, *Darkest Hour,* shows Churchill in 1940 being tempted by cabinet colleagues to seek peace with Hitler. He was fully aware of the cost to be paid for resistance.

401 Prudence would have delayed fortitude just sufficiently to grab a bag containing dressings, syringes and morphia.

402 His torment could be seen as a variant on the 'trolley problem', and the triage of the battlefield meant choosing some and passing others by.

403 J. S. Mill was described by Heyd as being 'very cautious about supererogation' in *Utilitarianism,* but he was much more welcoming in *On Liberty.* Heyd, 83-85.

have been a drawback, rather it would have spurred him on to restore his former reputation (the alternative was to do nothing, and that would have been impossible for a man of his character). The second doctor is tormented by Morton's fork, or the Cornelian dilemma, choosing one of two equally objectionable paths. If he holds back, as he prefers to do, then his new-found reputation for bravery would suffer ('Go on, Doc! Even Captain Chavasse would have a go at that, he's already got one VC. Have a go yourself!), but if he went forward then he would be putting himself at risk and, perhaps worse in his own eyes, neglecting those many men already wounded who needed his continuing attention.

5.8 Choice and Potential Regret

In the realm of our Gyges-constructed narrative the second doctor does in fact act spectacularly; he goes over the top as Chavasse would have done, and this he does despite misgivings, indeed against his better judgement.[404] What drives him to do this is the simple fact of the *vis a tergo,*[405] that pressure from behind, the taciturn commanding officer saying, 'No pressure', yet looming over him nonetheless; the men in the trenches, wincing with pain when the cries of the wounded men reach their ears. We hesitate to see him go, fearing for him, yet acknowledging that the risk of being wounded seems less dreadful than the mental anguish we have put him under by conducting this experiment. We wish him good luck - as he goes over the top, reaches the injured and saves some of them; we also wish him the moral luck that none of the men in the field hospital die while he is gone.

In fact we can distinguish further at this critical point: if the doctor had gone over the top believing that his action was truly optional then he would be acting supererogatorily. If he had gone over the top, all the while fearing that if he had not done so then he would have been condemned, that would illustrate so-called 'Forced

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[404] A poem which reflects on choice and potential regret is *Annunciation* by Denise Levertov. Mary is offered 'the astounding ministry' of bearing Christ, and how 'courage unparalleled, opened her utterly'. We might turn away from such momentous opportunities, for safety's sake, 'but the gates close, the pathway vanishes', and then we live with the consequences. Denise Levertov, 'Annunciation', in *A Door in the Hive* (New York: New Directions, 1989), 86-88.

[405] *vis a tergo* and *vis a fronte* are applied in medicine to the physiology of the circulation of blood. The heart pushes blood into the arteries (*vis a tergo)* but also pulls blood back from the veins *(vis a fronte)*.

Supererogation', recently described by Cohen, which can be fairly acknowledged.[406] Further solace for the distressed doctor could be obtained by thinking that his obligation to the already wounded was somehow equalled or exceeded by going out to the men in the open; it is possible to believe that a doctor in that situation would be so moved by the cries of the wounded that his thinking could shift as he stood in the trenches.[407]

One of the chief drivers of this imaginary, melodramatic twist is to put the actors under pressure: they remain on stage but do not know their lines. Bernard Williams did not write about supererogation, but he was interested in opera with its unlikely plots, its twists and turns, and the severe pressure put upon the singers musically and dramatically. I do not think he would have dismissed 'supererogatory duties', described by Brenda Almond, as a tautology,[408] indeed his favouring of ethics rather than morality allowed non-moral factors to be counted in the scale. He valued the complexity of life, not the idealised and distant moral theories which claim so much. We can say that rescuing the men in the fox-holes was important for Chavasse; the second doctor was aware of this, but wanted recognition of the importance of not abandoning the men he already had in the field station. This is the sort of complex computation that Williams was driving at; above all he was concerned with 'intimations of a genuine social reality - in particular, of how it will be one's life with others if one acts in one way rather than another.'[409] A distinction between the two doctors is that Chavasse was acting as a man whose duties and obligations were one and the same, melded together. The second doctor I see as having made a separation between the personal and professional aspects of his life; that separation might be more apparent in some doctors than in others.[410] Regret for action not taken seems inescapable in such crises.

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406 Shlomo Cohen, 'Forced Supererogation', *European Journal of Philosophy,* 23 (2015), 1006-1024. It comes into play when the only choice is between heroic action and action which others are likely to condemn. He gives the medical example of being the only match for a family member who needs a kidney transplant.

407 Swinburne reaches such a place in his 'final version of the traditional account' of moral responsibility. Swinburne, 37.

408 Brenda Almond, 'Reasonable Partiality in Professional Relationships', *Ethical Theory and Moral Practice,* 8 (2005), 155-168.

409 Williams, 102.

410 The memorial statue in Abercromby Square, Liverpool shows Chavasse pulling the wounded to safety, an action any soldier, medical or not, might have attempted.

This is the importance of autonomy and of how it can be lost sight of at a critical moment. Tragedy comes in because vital decisions have to be quickly made, and then, successful or not, such decisions become hostages to fortune. It is as if our autonomy becomes a will-o'-the-wisp; the more we try to grasp it the more it eludes us, for outside forces drive us on.

5.9 Shame and Necessity

Let us leave the characters in that heightened state: Chavasse, straining at the leash, anxious to do what was right in his eyes, and never mind his colleagues who now saw him as timid; the second doctor going over the top in a turmoil of feelings. In *Shame and Necessity,* Williams portrayed the ancient Greeks as driven by the fear of shame, something he distinguishes from guilt by the forensic analysis of motivation and expectation. The doctors above are driven by fear of shame; the shame of doing badly on the battlefield contributes greatly to that requirement of comrades in arms not to let each other down.

Civilian doctors can feel shame, along with guilt, in harming a patient, and this shame is first experienced on ward rounds when a student or junior doctor proposes a diagnosis which is wrong. Those moments of humiliation are remembered; they are the adumbrations of shame which are waiting to be felt at a later date when things do go wrong and the sense of our failure leaps into salience. We then realize our treatment has harmed the patient, and we feel as if the world has lost its foundations, or as if we have suddenly been exposed defenceless on the ward round again (Bernard Williams relates shame to appearing naked before others).

5.10 The Motivation for Acts of Supererogation

Should we therefore suggest that one of the prime drivers of supererogation is the fear of shame? I mentioned the column of Aquinas at the beginning of this chapter, and I imagined the supererogatory few at the top of the column in a state of unapproachable refinement of feeling and behaviour. This view of morality as a column of aspiration, as portrayed in the Beyond Duty model, has here been turned through ninety degrees.

This alternative view turns the column onto its side; here supererogation and duty are more shoulder to shoulder, for indeed we are all perhaps capable of extraordinary behaviour at times. The outstanding work of doctors and other health care professional in the COVID 19 pandemic shows this clearly.

The image of the main stream sheds light on this alternative presentation. We can also see supererogation in the guise of side-shoots to ordinary life, rather than the refined top-dressing entailed by the separation of precepts and counsels. These hold little sway in this second model, for in the professional setting so much which seems extraordinary is in fact part of operational procedure. The pilot whose plane was disabled after collision with flocks of birds in January 2009, not only managed to make a safe descent onto the Hudson river, but then made sure that everyone was out of the cabin before standing with them on the wings.[411] This was admirable, but within the context of what might be expected from the captain of a plane, it does not seem quite right to describe this as heroic. Of course we wish to *see* his actions as heroic, but time and again, rescuers describe themselves as simply doing their duty, or just doing their job, or doing nothing particularly noteworthy at the time.[412] Such responses can be anticipated as part of the 'furniture' of an occupation. The pilot's training would have included making sure the passengers were safe before thinking of himself; indeed he would have had no peace of mind if this had been omitted. We live with the consequences of our choices, and the best antidote to regret is the belief that everything was done that could have been done.

The Beyond Duty model and the Supererogation as Sacrifice model are equally costly; indeed when walking on the limestone pavements of the Yorkshire Dales one can come to harm by slipping on the horizontal surface of a 'clint' as easily as slipping down a vertical 'gryke', with a twisted ankle the price of not paying attention to one's footing. Aquinas' view inclines us to see a hierarchy with the more worthy at the top, as opposed to the side-by-side divisions proposed here which can separate us in what could be described as an attitudinal way. I see here not so much an aspirational ascent, more an alternative view which has the flavour of simply getting on with the

411 https://en.wikipedia-org/wiki/US-Airways-Flight-1549 [accessed 17 October 2022]
412 The last surviving Battle of Britain pilot died in 2018. He said, describing the dog-fights in the South of England in 1940, 'They were interfering with the cricket'.

job, of doing what needs to be done. Aquinas' view is one of the self-sacrifice of worldly appetites and advantages; this model takes us away from the mainstream where there is more exposure, with less protection from the bulk of other participants.[413] Aquinas sees supererogation as resting on the foundation of the majority who are only able to follow the precepts; this new model sees oneself as flying at the edge of the flock.

Looking again at the base of the column of the Beyond Duty model, we ask are the foundations not settled on dreadful feelings of shame and disgrace? Is this not simply the counterpart to the rarefaction at the top, peopled there by characters who are more ethereal when compared to the earthly heaviness of those at the bottom? This view of supererogation would keep the column in its vertical position, while we would be naturally graded according to place. Those weighed down with base considerations would be stuck at the bottom, and only those who have shed the weight of self-concern would be able to rise to the top. My new horizontal model might get rid of some of the shame, and also the sense of inferiority of only barely performing one's duty. At the same time we should be careful not to see supererogation in a calculating light, with the effort of getting to the top experienced as a desire to get away from the masses in an aspirant climb towards self-betterment. Supererogation would then become a move of social mobility, benefitting others of course, for that is a requirement, but also raising us up and doing us no harm at all (if we could only ignore the heads and shoulders of those we stand on in getting a step up). That scramble for place would reveal vanity as being the motivational force.

Let us now keep the column in this horizontal position and survey it afresh. What makes the horizontal view a more rewarding perspective? Firstly, we can see Chavasse once again, this time at close quarters. That is an advantage, not in knocking him off a pedestal, but in grounding our expectations of him. He can become, once again, one of us. This allows us to place ourselves alongside him and to think that heroic supererogation might be attainable by us as it was by him. It would also alter the character of supererogation itself; it would no longer be seen as

[413] A flock of birds does not wait for late-comers, just as convoys could not slow down to wait for ships which had fallen behind. We sacrifice some freedom by joining the crowd just as we put ourselves at risk by departing from the mainstream.

always heroically or nobly blessed (and Chavasse did not see himself in such light) but as an action, a way of life, which might be amenable to all, if only rarely achieved. That would make extraordinary service to others into something to be reckoned with as an everyday occurrence, not something beyond our reach.

The 2018 rescue of a football team of boys from flooded caves in Thailand was achieved by a large team which included an Australian doctor, Dr Richard Harris, who was both an anaesthetist and an expert diver.[414] He was able to reach the boys, to sedate them before their underwater journey, and to bring each one to safety. His unusual combination of skills made him just right for the attempt; indeed if he had not come forward to help might he not have felt shame in leaving it to others? It seems that we feel a compulsion to act in such circumstances, especially when we are one of the few people who have a unique set of the required professional skills. In this respect his great feat makes supererogation feel less special than formerly, but makes duty feel more special in itself, changing our sense of duty into something no longer irksome but pleasurable if approached in the right spirit. That might sound high-flown, but I am thinking of the transformations brought about by attitudinal change. As a medical student I had an initial distaste for helping patients to clean themselves, but this was transformed by a week of nursing experience on the wards, taking place soon after our clinical studies began. I had to 'shadow' a nurse, doing everything that was needed. It was the good-natured kindness of the nurses which was so noticeable and indeed so touching, especially when attending to the most incontinent patients. That is a modest example of this transformational aspect I am seeking, redirecting fastidiousness into the service of others.

Now that the column is horizontal we no longer find supererogation located at one end of the column, rather we find incorporations of supererogation along the whole length, that is, in the social body of our shared life. There is no top or bottom to those inclusions. There is an ancient Roman stone column adjacent to York Minster; it was discovered underground during archaeological work but was then re-erected. It can be seen to be made up of compacted stones, like sand grains, with inclusions of other stones. If the column represents our dutiful service to each other, now all compacted

414 Divers from many countries volunteered and were involved with the rescue. Dr Harris was decorated for his bravery.

and solidified together, perhaps the inclusions can be seen as memorial fragments of supererogatory experiences. The soil of Flanders is heavy with the memory of the soldiers who died there doing their duty, and a few like Chavasse who did something extraordinary. The soil is impregnated with their blood and the memory of their actions, just as the column laid horizontally emphasises the earthly origin and more grounded aspirations of this new view of supererogation. Here we see supererogation and duty intimately mixed up; we are all contiguous with each other in our triumphs and disasters. On the battlefield especially, we might see ourselves no longer as individuals but as part of a greater whole. Indeed, Chavasse's team of stretcher bearers suffered alongside him; his heroism supervened on their courage, and their sacrifice has not been brought to public notice.[415]

Chavasse belonged to a late Victorian and Edwardian generation, with an esprit de corps resulting from the cultural beliefs of a nation and a class. That cadre is now broken up, and he seems much more distant from us than a mere century away. Duty and supererogation were not sharply defined for him; they merged into one, and neither one nor the other was especially worthy of notice - one simply got on virtuously with the job in hand, wherever it might lead.

5.11 Conclusion

In this chapter I have described a new model for the better understanding of supererogation. It might be argued that the qualities shown in wartime, displaying the heroism and courage of soldiers under fire, do not make for a good and answerable account of the concept. Yet rather than seeing these as just particular accounts of doctors in peculiar circumstances, I think they do illustrate vividly the living force and attraction of high levels of service for others. Though shown here in the spectacular heroism of Chavasse, such sacrifice moves us all. *Philia* becomes transformed into *agape*. Yet for such a hero as Chavasse, supererogation is continually merging into duty, at least *in foro interno*, the two finely combining together as in the column, and

[415] Clayton, illustration no. 25. They are pictured in a regimental photograph from 1917. They are wearing kilts and Balmoral bonnets with pom-poms, and with SB on their arm bands; and although I expect they wore steel helmets at the front, the poignancy is unbearable. One of the men was killed with Chavasse, and two of the men display Military Medal ribbons.

thus the concept disappears before our eyes. That disappearance is most evident in times of war, perhaps to separate out again in times of peace.

We can say that spectacular supererogation is seen in the heroism of Chavasse, yet the heroic and the spectacular do not always coincide. Spectacular heroism is therefore just one aspect of this concept, and quiet forbearances can be just as praiseworthy and worthy of our notice. What links the examples shown here is a triad: a willingness to leave ourselves vulnerable in the service of others; a sharing in the suffering of others; and a forbearance from being rescued while others are in desperate need. These are the loving foundations of our motivation when our service is most clearly directed towards others.

At the start of this thesis I emphasised that supererogation as a concept should be retained in medical practice; it has important things to say to doctors about the nature of their duty and how to pursue excellence in practice. What I am finally seeking is a model and a practice of supererogation which is applicable in ordinary times, not simply in times of war. In the next chapter, with this in mind, I describe a third placing of supererogation on a different basis.

6. Chapter Six: A Third Model: Supererogation as Secular Sanctity.

6.1 Introduction

The genus of supererogation can be divided into three species or models: the *Beyond Duty* model based on Aquinas was described in chapter 1; a second model, *Supererogation as Sacrifice*, was developed in chapter 5. Neither model has ready application in modern medicine. A third model, *Supererogation as Secular Sanctity*, is now introduced. I recommend it for doctors who are interested in supererogation because it is readily applicable in practice, and I also suggest that it points to improved job satisfaction for doctors who choose to work in this manner.

I describe the roots of our relationships, and then return to the *telos* of medicine and show again how this can become perverted if we lose sight of pity. I indicate how doctors can remain alive to the suffering before them. The work of Iris Murdoch gives a guide to the moral psychology of this model, indeed it takes us to the philosophical heart of the matter. I then describe two doctors in illustration.

This model moves away both from the theological precepts and counsels of the first, which saw a cleft between ordinary and speedier routes to salvation, and from the second, sacrificial model which saw a running together of ordinary and exceptional service to others, at least in the case of Chavasse. The governing idea of this model is the dynamic nature of our relationships: we oscillate between self-regarding and other-regarding states of mind. It seeks to transform any costs of supererogation into a new perception of ourselves in the light of our service to others. I therefore endorse this model as appropriate for doctors, believing that it is capable of bringing benefits to patients and doctors alike.

6.2 Characteristics of the Third Model: Roots of Relationship

Supererogation in this third model focuses on the deep and stabilising roots of our relationships. It is based on the assumption that the division between the counsels

and precepts of the Beyond Duty model is not water-tight: there is movement across that barrier which is more permeable than supposed. We can therefore discard the assumption that precepts are always sufficient for our moral purposes. This model does not call upon doctors to sacrifice themselves for the sake of others, at least they need not set out to do so. On the contrary, doctors are keen to preserve their separateness from patients, no matter how much they might be moved by their distress. We remain separate from each other, and importantly, we do not seek to appropriate the other to ourselves, a danger shown in the novels of Henry James and studied by Jill Larson.[416] These separate but contiguous roots of our relationships are out of sight, hence overlooked. In this third model, as with the other two models, duty is represented by the trunk of a tree, its bark hardened by the sun and rain, illustrating the solidity of what we *have* to do in order to keep our whole structure standing. Here it is the roots which compel our attention, not the flowering branches which so easily attract us in the *Beyond Duty* model; or the trunk itself which represents supererogation merging with duty in the second model, at least as illustrated by Chavasse. Doctors are so busy dealing with the visible that we have come to leave those roots underground and undisturbed.

What makes this third model distinctive is the fact that our sensibility towards others waxes and wanes; sometimes we are finely attuned to others, sometimes much less so. Acts of supererogation are 'desirable but optional', and although blame does not attach to their omission, nevertheless the enduring legacy of the Beyond Duty model is the fact that 'the path less chosen' always remains desirable. This model is about how we handle that desirable aspect, especially how we might allow some fulfilment of that desire in busy medical practice. As Heyd points out, referring to Aquinas, if that path of the counsels is the '*better end*' then we are dealing with "the perfection of human life", which is man's total preoccupation with God'.[417] The assumptions of mediaeval society are far behind us, yet irrespective of religious belief we retain a desire to do the best we can, indeed to become the best sort of person we might be, as with the consultant doctor undergoing his Damascene conversion described in section 2.2.4.

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[416] 'True empathy, paradoxically, involves not "living for others" but recognizing their separateness and allowing them to live for themselves, feeling with them but not appropriating their feelings'. Jill Larson, *Ethics and Narrative in the English Novel, 1880-1914* (Cambridge: Cambridge University Press, 2001), 104.

[417] Heyd, 20. Heyd refers to *Summa Contra Gentiles,* bk 3, pt 2, chapter 130.

We oscillate between being 'a good enough doctor' and one who is striving for 'the best one can be'.

I justify the introduction of the third model on the basis of the inadequacy and breakdown of the modern biomedical approach which, notwithstanding its superb achievements, can leave some patients - the invisible - stranded and uncared for. Invisible patients are those who are not readily amenable to a biomedical approach: the chronically sick; the severely disabled; patients with intractable learning difficulties or personality disorders; they can be marginalised in modern medical systems. I suggest this third model allows us to extend these biomedical achievements to all patients, including those who are incurable, and also those beyond the reach of modern medical systems which prefer to pick the low-lying fruit on the grounds of efficiency and ease of approach. This third model is about the need to develop our sensibility to the suffering of others; it is an invitation for doctors not to concentrate simply on 'the presenting complaint' but to look for signs of deeper distress. This requires doctors to cultivate sensibility, a difficult art, allowing us to see patients in all their multifaceted complexity, and needing mental effort and imagination to work hard in the service of others, along with the wisdom to know how biomedical knowledge can best be applied.

We saw in *Supererogation as Sacrifice* how a medical soldier gave his life in the service of others. The First World War now seems very remote from us, and the social assumptions then taken for granted have changed profoundly. This third model aims to keep the benefits of supererogation in mind while reformulating it in light of the societal changes of the past century. I see this as a more modulated approach, holding its place amongst the self-regarding mores of a consumerist society.

6.3 Blindness to Moral Obligation

If we think of attaining the *telos* of medicine - the care of patients - as encompassing the whole of medical activity then some doctors become so fascinated by specialist knowledge that they lose sight of the whole. Specialist knowledge deepens our knowledge of particular diseases, but the danger is of losing sight of the summit, as

doctors might lose sight of the *telos*. For example, the doctors at Tuskegee, USA, described in section 2.2.5 above, had lost sight of the *telos*; they were so preoccupied that they became blind to their moral obligation, namely not to cause harm, and that must have included curing them of disease when new treatments came to hand. That should have come first, the research second. The investigation of disease can become dangerous when detached from moral obligation.

The *telos* of medicine needs to be kept continually in mind; it is not something that can be thought of as a goal beyond our reach, rather it should inform every step of the journey. Coleman points out the dangers of losing sight of the end by concentrating too much on the means. She points to Aquinas and Aristotle and their distinction between 'natural ends or goals and coincidental or accidental ones', mirrored in MacIntyre's 'distinction between internal and external goods'.[418] The danger for doctors and patients is that medicine can become vicious, not virtuous, and we wonder how this can happen when doctors are well-intentioned. I suggest it comes from the detachment from pity when it then seems easier to concentrate on the means to ends rather than the ends themselves. With this in mind I next examine the suffering of patients and see how doctors can best respond to that call.

6.4 The Suffering of Patients

How can doctors remain alive to patients and not become impervious to their suffering? The worry is that the doctor who loses sight of the suffering loses sight of the patient, and this might result in the doctor becoming indifferent to patients or even despising them, as George Orwell described in his 1946 essay, *How the Poor Die.*[419] Coleman points out that with regard to the *telos*, or 'final end', Aquinas states that we need to be certain of the knowledge that directs us there. This knowledge is given to us by Christ who has shown us 'indemonstrable first principles',[420] which in turn are given to us so that we 'can receive a knowledge of divine matters *in a human way*'.[421] Furthermore, we are not to think of this as a mystery; those ends are 'already there and

418 Coleman, 83.
419 Orwell was a patient on a public ward in a Paris hospital in 1929 and describes his dreadful experiences. George Orwell, *Essays* (London: Penguin, 2000).
420 Coleman, 85.
421 Coleman, 85.

graspable as such by rational human agents who think the true and desire the good'.[422] Medical sociology points to the worrying gaps between doctors and patients when such fundamental goodness has been put to one side. Aquinas gives a full account of the obstacles to the good which we should be aware of and learn to overcome. Of particular note for ambitious doctors in his demonstration that human happiness does not consist of honours, glory or riches (*SCG*. 3; 28-30).

How do we reconcile this gap between our tender feelings towards suffering patients with our rational opposition piled up against self-sacrificial involvement? One answer would be the approach of MacIntyre whose emphasis on 'a coherent tradition' is a foundation of his philosophy.[423] He took pains to keep methods and means embedded in the traditions of practices so as to prevent deviations becoming so wide that the whole practice of morality deviated from the good.

A recent example of this false separation between ends and means is highlighted in the scandal of obtaining factor VIII, derived from blood, for haemophiliac patients in the UK from the USA. Once again, this example shows the divergence between professional duties and moral obligations. The donors included prisoners, drug addicts and prostitutes, and they were typically paid for their donations, but testing was inadequate, resulting in recipients contracting serious diseases. Accounts of the scandal give a picture of supplies being obtained from any source; the welfare of the patients in the UK was disregarded, indeed the *telos* of medicine was lost when the urgent need for factor VIII was met irrespective of the risks involved. As all this could have been foreseen without any specialist medical training then we could describe this as a case of neglect of our moral obligations as much as our professional duties, and we can just imagine the sloppy thinking behind it: 'We're running out of factor VIII ; I've heard there's plenty going in the US; Has it been tested? I expect so; then let's get some.' This sort of technical solution is all too common in biomedicine, with doctors choosing to remain unaware of the wider consequences. I suggest that MacIntyre's 'coherent tradition' is an invitation for doctors to pay respect to the traditions and working practices from before the age of biomedicine.

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422 Coleman, 86.

423 Gordon Graham, 'MacIntyre's Fusion of History and Philosophy' in *After MacIntyre,* ed. by John Horton and Susan Mendus (Cambridge: Polity Press, 1994), 167.

Such medical failings point to the lack of what I label the 'family standard': 'Would I be satisfied if this medical product were to be given to a member of my family?' This astringent standard cuts through all business thinking along the lines of costs and ease of procurement; furthermore the 'family standard', if regularly put into practice, would glue together professional duty and moral obligation, indeed it should be applied whenever we suspect a tendency for divergence to occur. Those tender feelings constitute the knowledge that guides us to choose the right means to an end. We can remain alive to the suffering of patients by acknowledging that the *telos* of medicine requires us to be aware of the whole person before us.

The single-mindedness of much biomedical practice might lead us to lose sight of the whole; it is then that the neglect of the *telos* becomes apparent. In order to counter such tendencies I propose that doctors should regard the suffering of patients as the lodestar of their work, the constant centre around which swirl their multifarious medical activities. It is then that the *telos* of medicine would not be lost sight of despite the undoubted, sometimes spectacular, achievements of biomedicine. Fortunately there has been much recent scholarly interest from sociologists in the suffering of patients and how doctors might respond to this.[424]

6.5 The Three Models Compared

With this emphasis on relationship, let us look again at the three models. The *Beyond Duty* model displays a separation between ordinary life and the life of supererogation, a view looking upwards to salvation. For Christians who sought out a life of asceticism for the sake of others, supererogation could be described as the stepping-stone to a life devoted to God, and indeed facilitating the passage to perfection. That was too demanding a step for most; it belonged to the world of counsels which were

[424] Arthur W. Frank, *The Wounded Storyteller: Body, Illness and Ethics* (Chicago: University of Chicago Press, 2013). Frank, 'Suffering, Medicine, and What Is Pointless', *Perspectives in Biology and Medicine,* 62 (2019), 352-365.

beyond the of reach of the majority, requiring courage, resolution and self-denial. *Supererogation as Sacrifice* shows a sense of continuity between precepts and counsels, perhaps seeking to find a small piece of heaven on earth. Indeed when going through hell on earth we try, as Etty Hillesum said, to find God within us.[425] The third Model, *Supererogation as Secular Sanctity*, shows that the tender roots of our relationships, though hidden from view, are continually rising into salience: pity might arise in us but then might be put aside as we concentrate on the job in hand.

In the third model the gap between duty and supererogation is not so much a formal divide, rather a zone of increasing refinement and growing spiritual intelligence. Supererogation can here be seen as the quintessence of duty, so finely refined as to free itself from the baser elements in the original mix, e.g., that dreary and resentful sense of having to get up and do our duty. This can be compared to the distillation of crude oil which separates the heavy, sluggish tars at one end of the spectrum from the clear and volatile distillates at the top end. The important point is that all these fractions are present in the original product, it is just that the higher end of distillation is not visible in the crude oil at the beginning. Who would have known that crude oil, before it was first distilled, could ever have been compounded of such base and ethereal elements? I liken the volatile distillates at the top end of the spectrum to those rarefied elements identified by Charles Taylor (section 2.2.2), which includes supererogation; without these distillates we suffer from the 'distortion of our moral experiences based on obligation' which Taylor complained of.

The natural presupposition for the *Beyond Duty* model rests on the distinction between precepts and counsels. For the third model the natural state is a mixture of many things, like the creatures in Noah's Ark,[426] with supererogation only becoming apparent after the application of energy, i.e., the mental energy required to perceive things with more spiritual refinement. That energy stems from, and derives force from, witnessing the pain of others and the pity which that evokes. It is pity which evokes finer feelings, leading us to act more lovingly towards others.

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425 Etty Hillesum died in Auschwitz in 1943. When things are terrible on earth 'we safeguard that little piece of You, God, in ourselves', and we have to 'bear witness to the fact that God lived, even in these times'. Rowan Williams, *Luminaries: Twenty Lives that Illuminate the Christian Way* (London: SPCK, 2019), 134-135

426 Genesis 6. 9.

The weakness of the *Beyond Duty* model is that most people are left conscious of their second-class status, notwithstanding Aquinas being mindful and forgiving that most people simply could not rise to the level of counsels. This separation is inherent in the division between precepts and counsels, and perhaps leads to a resignation amongst the lower class because separations between us may lead to qualitative perceptions of higher and lower castes.[427] This third model permits us to see supererogation as arising anywhere within the whole, not from particularly gifted individuals, just as bubbles arise randomly from the surface of the oil in the distillation flask. I am here seeing acts of supererogation originating like bubbles from the chemical mixture, perforce attached to particular individuals, but not necessarily unique to them.

Such actions are motivated by the sight of the patient before us, and pity is the energy which makes the supererogatory the first distillate to emerge from the flask. Supererogation can be seen as the occasional, idiosyncratic response to that suffering, over and above the fulfilment of duty, yet it can also be seen as a more profound attempt to reach out to others, to extend a helping hand, or rather to reach down into them, even at cost to ourselves. The force behind that is the ideal of attaining a state where our own advantage is shared with others, people who are no longer seen as separate from us but contiguous with us, albeit not part of us ourselves. I am not suggesting that this is a state of mind which is often obtained, or which should be sought on every occasion; rather it represents the penetration of pity into our hearts which leads us to act in exemplary ways.

6.6 Iris Murdoch: Avoiding Mechanical Rigidity

Medical practice can get by with very little penetration of pity into doctors' hearts, at least for those who choose to be impervious to such things. I put this down to the rigid way in which much medical practice is undertaken. Knud E. Løgstrup has described how mechanical our lives can become:

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427 'The great error of the invalid theory . . . was the suggestion that anyone who for whatever reason refused this 'generally higher' way of life was *ipso facto* debarred from the highest rewards or attainments of Christianity'. Kirk, 520.

> No one is more thoughtless than he who makes a point of applying and realising once-delivered directions . . . Everything can be carried out very mechanically; all that is needed is a purely technical calculation.[428]

In chapter 4 I described the dangers for Septimus when his doctors were rigid in their approach and thinking, and a philosopher who argued against rigidity in professional and personal life was Iris Murdoch. Her work indicates how doctors can be professionally committed while remaining both light on their feet and alive to the suffering before them. Murdoch refers to duty, finding that for the most part we do it without too much strain:

> The concept of duty does not require the concept of will, innumerable duties are performed without any place for it: Hume's 'habit and custom' for instance, and perhaps Wittgenstein's 'Forms of Life'. In a good man duties are more like habits.[429]

This is important for doctors who practise the third model of supererogation: not only are duties internalised, becoming a habit and so less irksome, but our whole habitus becomes a norm of embodied virtue. In commenting on the approaches of Schopenhauer and Wittgenstein to Kant's conception of duty, Murdoch writes that,

> But a realistic view of morality cannot dispense with the idea; duty is for most people the most obvious form of moral experience: Kant's starting point. One might say that morality divides between moral obligations and spiritual change. The good life becomes increasingly selfless through an increased awareness of, sensibility to, the world beyond the self.[430]

This suggests the grounding of a basic sense of duty as an everyday requirement but with opportunities for supererogation transcending the ordinary. In two contrasting passages Murdoch captures the oscillation we feel as we alternate between self-regarding and other-regarding states. Firstly, there is the notion of being stuck in a

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428 Knud E. Løgstrup, *The Ethical Demand,* translated by Theodor I. Jensen (Philadelphia: Fortress Press, 1971). Quoted in Zygmunt Bauman, *Postmodern Ethics* (Oxford: Blackwell, 2004), 79,

429 Iris Murdoch, *Metaphysics as a Guide to Morals* (London, Vintage: 1992), 53.

430 Murdoch, *Metaphysics,* 53.

state of irksome resentment about our work; she comments on Simone Weil's description of the 'gravity' which pulls us inwards to self-regarding conduct:

> Better conduct is often harder and less natural than mediocre or bad conduct. It is not easy to sacrifice strong egoistic attachments or break bad habits. We 'satisfy our conscience' by doing half the task; surely more cannot be required of us. We can always say: well, other people do this. These are among the best-known facts concerning the human condition.[431]

By contrast she refers to Kant's treatment of the subject of desire:

> The good (better) man is *liberated* from selfish fantasy, can see himself as others see him, imagine the needs of other people, love unselfishly, lucidly envisage and desire what is truly valuable. This is the ideal picture.[432]

The notion of sensibility is important for Murdoch, not surprising as she was a prolific novelist. I interpret 'sensibility' as a sensitivity to our feelings intertwined with an awareness of the feelings of others, coupled with an appropriate responsiveness so we know when to intervene. With the novelist's eye for detail she valued paying attention to others as a link with morality:

> Moral change comes from an *attention* to the world whose natural result is a decrease in egoism through an increased sense of the reality of, primarily of course other people, but also other things.[433]

In this regard we can see that supererogation, done for the benefit of the patient and not the doctor, is about a decrease in egoism of the agent in favour of the patient, but it can only be achieved gradually. It is the path of 'a long deep process of *unselfing',* not achieved through will-power and strain but by seeing things in a new light in the pursuit of *metanoia*.[434] The emphasis on sensibility runs through her work and contrasts with the lack of sensibility of the doctors who attended Septimus in *Mrs Dalloway.* Much work is needed to achieve an appropriate sensibility:

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431 Murdoch, *Metaphysics,* 331.
432 Murdoch, *Metaphysics,* 331.
433 Murdoch, *Metaphysics,* 52.
434 Murdoch, *Metaphysics,* 54.

> Morality, as the ability or attempt to be good, rests upon deep areas of sensibility and creative imagination, upon removal from one state of mind to another, upon shift of attachments, upon love and respect for the contingent details of the world.[435]

Here Murdoch sees moral effort working in the direction of the good. Once again we can distinguish between doing more than expected without seeking praise or reward, as with people who claim to be 'just doing a day's work', versus those who make an effort towards the good, perhaps going against the grain, but in response to a heightened awareness of sensibility. There is the sense of mechanically just getting on with the job versus the effort of imaginatively thinking of what best to do next, a work of creative imagination. We can see a loss of sensibility running hand in hand with the dulling down of doctors when they are tired and overworked. A fine sensibility, along with scientific knowledge, is needed to judge the best way forward with new medical treatments, for there is no sense of 'one size fits all'. In philosophy this is represented by the tension between the separation of fact and value. Murdoch claims:

> Scientific views and methods spread from their proper place in science into peripheral areas. All sorts of theorists (including some philosophers) begin to feel that they must eschew value preferences and discussions of value, and offer themselves as neutral scientific workers. Surely, it may be felt, a clear-cut division of fact and value excludes personal prejudice and amputates whole areas of messy sentimental or muddled pseudo-factual thinking.[436]

That separation between the acquisition of medical facts and the wisdom of how best to apply them is at the heart of problems with the biomedical model. Good judgement is required, not an indifferent neutrality, for that suggests an abrogation of morality, not getting involved; rather it is about taking a larger picture, as wide as possible, and I again point to literature as an illustration. In Jane Austen's *Sense and Sensibility,* for example, Marianne is distraught on being humiliated by Willoughby at a public ball;[437] she recklessly displays her distress but is protected by her sister, Elinor, who shields her from gossip. This is how we can look after others when they are disabled by feelings of their own. Elinor's good sense is usually contrasted with Marianne's

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435 Murdoch, *Metaphysics,* 337.
436 Murdoch, *Metaphysics*, 51.
437 Jane Austen, *Sense and Sensibility* (Harmondsworth: Penguin, 1969), chapter 28.

sensibility, but there is two-way traffic: we grow in sensibility, not in florid declarations of how badly we have been used, but in loving awareness of the feelings of others, and how best to care for them in an appropriate way. This is a larger wisdom, and in the scientific sphere is illustrated by Murdoch:

> A serious scholar has great merits. But a serious scholar who is also a good man knows not only his subject but the proper place of his subject in the whole of his life. The understanding which leads the scientist to the right decision about giving up a certain study, or leads the artist to the right decision about his family, is superior to the understanding of art and science as such.[438]

This is sensibility again, here showing the notion of discrimination, pointing to the importance of good judgement and the fact that our moral obligations cannot be set aside in the light of seemingly competing and commercial ways of proceeding. Importantly, doctors should know their 'proper place' in the patient's life: to cure when possible, to care always, and not to abandon patients. The scandal of the doctors at Tuskegee showed medical knowledge being obtained at too high a price. We might also say that a wise doctor comes to know the *right* place of supererogation in her working practice.

Fact and value have become separated in scientific modernity, and Murdoch gives an insight into how and why this tendency took hold. It arose from a wish amongst philosophers and theologians for intellectual clarity, leading to a sequestration of all that is 'irrelevant and messily confusing' behind a border-line. She discusses Wittgenstein's change of method from the *Tractatus* to the later *Philosophical Investigations*, and she discerns a sense of loss: 'What we "lose" in the *Investigations* is some sort of inner thing'.[439] She points to a reduction in Wittgenstein's change of approach: he discarded the richness of our mental world, leading to the fear that our values might be 'illusory or else something small'. Murdoch comments that 'we may also end up feeling that we cannot now justify the reality or identity of our most important thoughts and most precious awareness. We are losing the *detail'*.[440] We

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438 Iris Murdoch, 'The Sovereignty of Good Over Other Concepts', in *The Sovereignty of Good* (London: Routledge, 2014), 94.
439 Murdoch, *Metaphysics,* 49.
440 Murdoch, *Metaphysics,* 49.

then tend to 'gather all the value together in one place' so that it does not contaminate factual knowledge, but the danger of this is the loss of that wisdom in how best to apply knowledge in the interests of the individual before us, not just the population whose pooled results have contributed to that knowledge. We lose the detail of the individual, compounded by a lack of sensibility; this corrosive lack of fine-tuning to the individual was shown in *Mrs Dalloway* and it remains a prevalent risk.

With such a common mode of thinking, hiving off important aspects of life into secluded compartments, is it little wonder we find doctors largely unaware of supererogation as an active ingredient of the world? It seems that doctors do not know what to make of it, just as Wittgenstein, according to Murdoch, did not know what to make of emotions.[441] We prefer to think in binary terms, illustrated in the division of the Good Samaritan's actions into what was required of him (carrying the victim to a place of safety) and what was not required (promising to pay the innkeeper on his return), when I think it is preferable to see a continuum of love and generosity on the Samaritan's part. Binary thinking allows us to focus heavily on duty and leave supererogation unexplored, but this thesis is about giving attention to both aspects. The fulfilment of duty, on its own, amounts to an adequate but sometimes truncated form of care. Recognising the messiness of life, we can say that we get drawn into situations where the easy erection of boundaries is idiosyncratic, if not arbitrary. When we allow values free rein in our thinking, instead of keeping certain concepts in the closet, then open-ended responsibility for others becomes something we cannot escape from so easily, as illustrated by Levinas in chapter 4. Murdoch describes this loss to philosophy, and I see a parallel in the blinkered doctor, before his Damascene conversion, walking down the corridor in chapter 3.

This section demonstrated the dangers of mechanical rigidity, and the richness of Murdoch's moral landscape reveals what is important but hidden from view. It amounts to a recognition that not all can be told if we continue placing important aspects of life in sequestered compartments of the mind. That division makes for easier analysis and depiction of things which are to hand, like duty for example, but leaves out the penumbra of obligation and wishes which we find hard to account for

441 'Wittgenstein detested muddled emotional talk.' Murdoch, *Metaphysics*, 51.

even to ourselves. This is how supererogation resembles a remote, unexplored land. I interpret Murdoch's philosophy as showing the artificiality of what we take for granted, and I suspect that Murdoch would have seen duty and supererogation, not in water-tight compartments but flowing into each other. Our obligations to each other are more connected with Feinberg's 'final human worth' rather than the satisfactory completion of any number of separate duties. Murdoch finished her essay on the Sovereignty of Good with a plea for humility. The humble person is likely to be aware that not all can be encompassed within the notion of duty, and that we are capable of extending ourselves to others in unforeseen ways. The humble person is least likely to see his own supererogatory actions with any sense of exaltation, and that is in accord with my claim that in this third model duty and supererogation are in very close proximity.[442]

6.7 Final Human Worth

Once again novelists help to point the way. A good example is found in Thomas Hardy's novel, *The Woodlanders,* in which Feinberg's 'final human worth', 'all things considered', is illustrated in the character of Giles Winterbourne. He is a modest woodsman who loses the love of Grace Melbury through misfortune, yet when she is later betrayed by her unfaithful husband, Dr Fitzpiers, she takes flight. She seeks shelter with Giles who, despite being ill, sleeps outside his hut so that her reputation will not be harmed. He dies of the pneumonia brought on by the lack of shelter. His final human worth is set against that of Dr Fitzpiers who, though worldly and philosophical, yet has low human worth because of arrogance. Indeed Hardy also suggests that Dr Fitzpiers' medical skills are undermined by his moral failure to his wife, for though he is able to act the technical part of the doctor when Giles is dying, yet he cannot rise to the level of excellence we found in Von Wright's analysis. This illustrates the central tenet of this thesis that moral obligation and professional duty go hand in hand; they cannot be separated without harm to everyone concerned.

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[442] We might go so far as to say that in this third model duty and supererogation are in 'superposition'. This idea from quantum physics suggests that the agent would not know whether he is acting in a dutiful or a supererogatory state; only the outside observer could say so, yet that very act of observation fixes the state into one or the other. The agent's felt experience might well be indeterminate.

Final human worth in medicine, as this novel shows, is not about mastery and control, as with the arrogant Dr Fitzpiers. nor is it just about acquiring technical skills, beneficial though they are, it is about allowing ourselves to approach the level of the weakest, to become meek, and then to use our remaining strength to pull others to safety. It is the contrast between what we could call the 'mastery and control' of the Ten Commandments, primarily directive in nature, and the quiet acceptance of the Beatitudes.[443] This is difficult for patients to accept when they are seeking a mastery and control approach to their problems, and this tension is reflected in the ambivalent attitude of patients to doctors who have themselves been ill and suffered.[444]

With such complexity in mind, this third model of supererogation is very much against any sense of 'dumbing down', for the danger of that is not so much the over-simplification of difficulties, rather it is the pulling down of higher levels of attainment, both professionally and personally. The *Beyond Duty* model sees idealism as not just over and above the everyday but far beyond it too; this model, by contrast, sees idealism and the mundane as rubbing shoulders together, and Giles Winterbourne shows just that. Perhaps we now pitch our lives with too much emphasis on precepts with not enough aspiration to the counsels. That is the prevalent legacy, enacted in a secular society, of the *Beyond Duty* model. This third model, by contrast, suggests a closer relationship between duty and supererogation, a transition more easily attained when we think of the distinction as being between different points of view, just as the ordinary and the extraordinary rub shoulders together in Murdoch's novels.[445] This model is therefore less about the strain of renunciation but more about the lowering of boundaries between categories so that the 'Obligatory', and the 'Desirable, but not Obligatory', are seen as neighbours across a wicker fence, not separated by difficult leaps into ethereal realms of self-denial or self-sacrifice. Murdoch's novels show that proximity: there is the Platonic searching for the ideal form of life along with continual entanglement with its contingent, impossible messiness of life as lived.

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443 David Cecil, *Hardy the Novelist* (London: Constable, 1978), 156. Cecil links Hardy's finest characters with the Beatitudes.

444 In Thomas Mann's novel, *The Magic Mountain,* the director of the sanatorium, Dr Behrens, has had tuberculosis but has made a good recovery. Not all patients are pleased to learn of this - that he is one amongst them.

445 e.g., in *The Black Prince* (1973) which is full of both ordinary and bizarre encounters. Iris Murdoch, *The Black Prince* (London: Vintage Classics, 2019).

Murdoch's novels and philosophy richly demonstrate the complexity of our responses; in particular she shows the attraction of the concept of the Good. The means to realising this end, I suggest, start with seeing the suffering before us; if that is not acknowledged then we are on unsure foundations. This is hard work; she describes it as a *'task* to come to see the world as it is',[446] requiring love based on the exercise of 'justice and realism and really *looking'*.[447] She says of duty,

> A philosophy which leaves duty without a context and exalts the idea of freedom and power as a separate top level value ignores this task and obscures the relation between virtue and reality.[448]

We saw duty as 'power as a separate top level value' embodied in Sir William Bradshaw in chapter 4. Murdoch provides much insight into duty, but nothing about the limits of duty. Furthermore, the emphasis on the Good is very marked. In a second essay, *On 'God' and 'Good'*, she examines the relationship between them, but argues that 'The old serious metaphysical quest had better now be let go, together with the out-dated concept of God the Father'.[449] This attitude appears to be a solvent to the problem of theodicy, but I think this is a false step: it discards a personal relationship with God, privileging an abstract, intellectual quest for the Good, itself left undefined and vague. As she admits, 'it makes sense to speak of loving God, a person, but very little sense to speak of loving Good, a concept'. Murdoch seems to be in danger of losing some 'inner thing', just as she felt that something was missing from Wittgenstein's account. She writes, 'that human life has no external point or telos, is a view as difficult to argue as its opposite, and I shall simply assert it'.[450] Furthermore, Murdoch prefers to view love in the guise of Platonic eros, manifested in the Good and in the particular individual.[451] The Christian God is lost sight of, and with it the comfort of religion; indeed she has no time for religion as consolation.

In support of the idea that we need direct connection with persons and cannot be satisfied with attachment to abstract concepts such as the Good, Christopher Cowley discusses the example of a father who gets up in the night to attend to his crying

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446 Iris Murdoch, *Sovereignty of Good*, 89.
447 Murdoch, *Sovereignty,* 89.
448 Murdoch, *Sovereignty*, 89.
449 Murdoch, 'On "God"'and "Good"', in *Sovereignty,*70.
450 Murdoch, *Sovereignty*,77.
451 Mark Hopwood, 'The Extremely Difficult Realization That Something Other Than Oneself Is Real': Iris Murdoch on Love and Moral Agency, *European Journal of Philosophy,* 26 (2018), 477-501.

baby.[452] He has no immediate tender feelings for the child but gets out of bed nevertheless, *not* from a sense of duty but because of the needs of the infant. This is a direct and unmodulated response. Cowley refers to Harry Frankfurt's claim that to think otherwise would be to interpose an object, as it were, between the father and the infant. We pray to God, not to the Good; we want to be in direct relationship, we want to be heard. I have noticed that dying patients need to be comforted by the direct bodily attention and touch of doctors and nurses; we do this not because it is a duty but because of a human need which calls for a direct response. This seems to be a manifestation, in adult life, of the 'holding' which was described by the paediatrician and psychoanalyst, Donald.W.Winnicott, as a vital force in the life of the infant. This idea was recently developed by Neil Vickers who perceived it in the life of adults, especially in those patients suffering from chronic incurable diseases or psychosomatic disorders.[453]

We might say that in such circumstances we should not over-think our behaviour: we touch patients not out of duty but out of love, just as the Prodigal Son is treated by his father with unmerited grace: 'his father saw him, and had compassion, and ran, and fell on his neck, and kissed him'.[454] We note that for doctors this is a reversal of the habit of disregarding our physical proximity to patients, of touching but not feeling. This is something which is most marked in the awkward intimacy of pelvic examinations: physically close yet remarkably distant, for our attention must not wander beyond the tips of the examining fingers. At such times we readily realize for ourselves, as doctors, that we normally and habitually adopt a detached stance towards patients. This can be so marked as to suggest a feeling of disembodiment, perhaps brought about by the fear of any inappropriate glance or facial expression on the doctor's part provoking embarrassment and complaint. How can we get round that professional stance of condescension towards patients, acknowledging our physicality while respecting their privacy?

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[452] Christopher Cowley, 'Introduction' in *Supererogation: Royal Institute of Philosophy Supplement 77* (Cambridge: Cambridge University Press, 2015), 16. Harry Frankfurt, 'Duty and Love', in *Philosophical Explorations* 1 (1998), 4-9.

[453] Neil Vickers, 'Winnicott's Notion of "Holding" as Applied to Serious Physical Illness', *British Journal of Psychotherapy,* 36 (2020), 610-620. 'Holding' includes touching and also the close support and care which seriously ill patients need.

[454] Luke 15. 11-32. Many paintings depict the embrace. Rembrandt's painting in The Hermitage is perhaps the most touching in this respect, but his etching and drawing are equally moving.

6.8 Putting Murdoch into Medical Practice

I suggest that if Murdoch's philosophy were put into medical practice then it would counter our disembodiment and lower our condescension. It would support the development of supererogation for several reasons.[455] Firstly, Murdoch directly links our perception of suffering and our desire to relieve that suffering. She would remove the intermediate steps of 'too much thinking' between us and the patient: as with the child crying in the night there is no sense of awaiting the call of duty before responding to distress. Secondly, she favours a moral realism such as the courage found in Chavasse; such qualities exist in the world and are not just interpretations we choose to ascribe to the world. Thirdly, the idea of universal principles as the basis of morality is shaken; instead Murdoch favours a moral particularism, and that calls for the ability to view things justly and with wisdom. A fourth feature, identified by Justin Broackes, is the anti-scientism in Murdoch, i.e., the opposition to the belief that science can tell us all we need to know about the universe. This is a point of tension for doctors: the accurate diagnosis of disease calls for a scientific viewpoint based on evidence, but the application of medicine calls for a different viewpoint, with a continual imaginative grasp of the suffering of patients. We should try to see how patients regard that suffering and how *they* judge the success of intervention. All that is personal, sometimes idiosyncratic, and is not scientific in the sense of there being only one impersonal, prevailing standard. In this respect Murdoch views art and ethics as sources of concepts which can 'guide and check the increasing power of science'.[456]

Murdoch promoted the idea of moral perception, of seeing what was morally important and acting upon that. Supererogation depends upon this stance: those doctors who are content to view the patient solely from the scientific point of view will offer the patient one intervention after another until some resolution is achieved. Those doctors who are attuned to what is important to the patient, but which is perhaps not amenable to science, will likely behave in a manner which goes beyond

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455 Justin Broackes, 'Introduction', in *Iris Murdoch, Philosopher: A Collection of Essays,* ed. by Justin Broackes (Oxford: Oxford University Press, 2012), 8-9.

456 Broackes, 'Introduction', 9.

that which is simply before their medical gaze: they will be capable of '*seeing* what is to be done'.[457] Importantly, those doctors who are attuned to this way of seeing leave themselves vulnerable to being seen, by which I refer to the reflexivity of our gaze: we look at the patient who is looking at us, with growing self-consciousness. Martha Nussbaum gives an example of how this can go wrong. She describes a strange meeting with Murdoch in which she was 'scrutinized' with great intensity during a conversation of two hours. Despite Murdoch's 'very intense gaze' Murdoch did not notice that Nussbaum could not eat the food that was offered for lunch, and that Nussbaum was too embarrassed to ask for something else.[458] This episode shows perhaps just how difficult it is for us to see clearly even when we are intent upon doing just that, or perhaps we can only sustain intense attention for short periods. The irony is that Murdoch was keen to break down our habitual egoism by 'unselfish attention to others'.[459] I suggest that Murdoch, on this occasion, was not properly aware of the reflexivity of gaze between herself and her guest; somehow it had become out of balance: in short, we need to be on more or less equal terms of vulnerability to each other's gaze to get things right. This difficult balancing act requires us not to focus too intensely on just one aspect of our interactions but to be simultaneously aware of everything that is going on. In this respect Murdoch writes of Simone Weil and her analogy of the 'mountain walker who is aware of what is very distant, what is less distant, what is near, as well as of the uneven ground beneath her feet'.[460] We then live in the present: 'I really see the face of my friend'.[461]

This seeing what needs to be done is difficult but not mysterious, rather it depends on seeing justly and generously, on a basis of caring for others. All these factors can only be brought to successful fruition when the agent has a good character.[462] A further illustration of the interaction of philosophy and literature was Murdoch's use

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457 Broackes, 'Introduction', 10.

458 Martha Nussbaum, 'Faint with Secret Knowledge', in *Iris Murdoch* ed. by Justin Broackes, 151-152. Murdoch offered a simple lunch, and seems to have penetrated into the heart of Nussbaum, yet provided food which Nussbaum could not eat: a strange dislocation showing Murdoch getting to the existential heart of her guest and yet not aware of her bodily needs.

459 Murdoch, *Metaphysics,* 301.

460 Murdoch, *Metaphysics,* 296.

461 Murdoch, *Metaphysics,* 301.

462 Bridget Clarke analyses Jane Austen's *Sense and Sensibility* to illustrate this linkage, with John Dashwood, after the death of his father, gradually uncoupling his duties to his half-sisters under the bad influence of his wife. He does not care for them as he should because of weakness of character. Bridget Clarke, 'The Prospects for Critical Moral Perception', in *Iris Murdoch,* ed. by Justin Broackes, 231-233.

of the first-person, male narrator in her novels; Peter Conradi claims that Murdoch 'felt instinctively at home', and that she could 'speak confidently through a masculine mask'.[463] The first-person, male narrator is found in six of her novels: *Under the Net; A Severed Head; The Italian Girl; The Black Prince; The Word Child,* and *The Sea, The Sea.* This male voice is thought to give the novels an imaginative leap into new territory, and to reveal the self-centred solipsism to which some of her male narrators are prone, especially in *The Black Prince.*[464] Margaret Moan Rowe notes that by 1980 Murdoch 'had abandoned a seeming obsession with first-person, and equally obsessed male narrators, in favour of an omniscient narration that privileges the views of a number of characters'.[465] Furthermore, the male characters often 'distort reality' because of their 'abuse of power'.[466] This points to the risk of dominating and silencing others. There again, it is contact with our inner life which seems a *sine qua non* of supererogation, for without it we are more likely to follow the well-worn path established by others, not striking out on our own into supererogatory territory. I suggest, as Nussbaum notes, that we only see clearly when we find 'a willingness to permit oneself to be seen',[467], and perhaps we could add to this a willingness to permit oneself to listen to others.

I am here claiming that Murdoch lays the foundation for a new way of seeing into the heart of things, and with this in mind we can say that she is seeing our moral responsibilities in a new way too. She sets up a different world,[468] preferring to talk of ethics as 'explorations' rather than 'analysis', and unsurprisingly for a novelist, she sees the need for 'a new moral vocabulary, a novel array of metaphors and concepts, to acquire an understanding or deepen our awareness of moral phenomena'.[469] We saw in the Beyond Duty model a picture of supererogation sitting on a base of duty;

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463 Peter Conradi, 'Holy Fool and Magus', in *Iris Murdoch,* ed. by Justin Broackes, 122.

464 'The self-centred life is antithetical to the good life she believes one should aspire to.' Gillian Dooley, 'Iris Murdoch's Use of First-Person Narrative in *The Black Prince*', *English Studies,* 85(2) (2004) 134-146, p.140.

465 Margaret Moan Rowe, 'Iris Murdoch and the Case of "Too Many Men"', *Studies in the Novel,* 36(1) (2004) 79-94, p.86.

466 Rowe, p.94.

467 Nussbaum, 152.

468 'Moral concepts do not move about *within* a hard world set up by science and logic. They set up, for different purposes, a different world.' Murdoch, *The Sovereignty of Good,* 27.

469 Carla Bagnoli, 'The Exploration of Moral Life' in *Iris Murdoch,* ed. by Justin Broackes, 200-201. Consultations with patients whose vocabulary is limited are 'thin'; they are barely able to say how ill they feel. Doctors are on the receiving end when travelling abroad and trying to describe something out of the ordinary with only a smattering of the language.

here we see duty, though well recognised by Murdoch as the central core of our relationships, obscured and enveloped by a huge atmosphere of supererogatory responses. We can liken this state to the planet Jupiter, a so-called 'gas-giant', which has a hard, solid core surrounded by vast clouds of gas, though with a dynamic interface between solid and gas. Her novels are concerned with interaction at this unstable interface of half-perceived needs and ill-defined obligations. Murdoch blurs the interface between duty and supererogation; we could say that those who are impervious to supererogation seem unaware of the gas cloud surrounding the core of duty, while those in favour of supererogation are more able to stand back and 'really see' the planet as a whole.

6.9 The Second and Third Models Compared

We remember the vivid illustration of *Supererogation as Sacrifice:* Chavasse defying the bullets as he attended the wounded. How does this third model compare with that? Roger Crisp provides illumination, giving the example of Madame Trocme, described in Chapter 1. She saved the lives of many Jews while fully aware of the peril; this was dangerous work of the highest noble value.[470] The philosophical question is, How did Madame Trocme estimate her own value compared with the lives she saved? While no easy calculations can be made, we can say that Chavasse estimated his own life to be of lesser value than that of the soldiers he saved, but this belief leaves 'no room for the self-regarding virtues, and attaches value to what might appear to be servility or self-abasement'.[471] Crisp finds that there is room for 'compassionate self-sacrifice in Murdoch's ethics',[472] yet he also cites our need for 'seeing correctly'; this does not include 'a complete blindness to one's own genuine needs'. This is tantalizing, but I suggest that in this third model we hold other-regarding and self-regarding motives in some sort of balance. Perhaps only saints and heroes are tilted firmly towards the other-regarding pole, the saints permanently, the heroes more impulsively. Humility points us towards the 'other regarding pole'. I therefore name this third model 'secular' in that it is not looking to the saints as

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470 Roger Crisp, 'Iris Murdoch on Nobility and Moral Value' in *Iris Murdoch, Philosopher* ed. by Justin Broackes, 284.
471 Crisp, 289.
472 Crisp, 289.

exemplars, not seeking salvation, rather finding a balance on earth, between serving others and looking after ourselves. In fact though, the situation seems even more complex than that. Lawrence A. Blum points out that Murdoch is concerned with what is morally good, not just with what is morally permissible:

> Murdoch's view is not concerned with weighing up benefits and losses. It is, in fact, not concerned with the agent's own benefit at all. It bids us to focus on others not at the *expense* of the self, but, so to speak, without considering the self at all. The moral task is not self-negation but self-transcending.[473]

I think we can say, in the spirit of Blum, that not everything can be captured by a calculation of profit and loss: we do not know at the start of an action what benefits might be accrued by either the donor or the recipient. This suggests that supererogation, even if costly, is quite capable of bringing its own intangible rewards. In medical practice these rewards might include a greater sense of service to others, more insight into the human condition, a sense of transcendence of our dutiful selves, and an approach to the *telos* of medicine which is rarely grasped in full measure. When fully achieved, such agents demonstrate a level of service to others which earns epithets such as 'hero' and 'angel' in the estimate of modern journalists.

6.10 Stepping towards Self-Transcendence

Supererogation can be seen as a means, a technique and a propensity for stepping towards self transcendence. This might sound grandiose when we think that most acts of supererogation are only modest. The strength of this model is the propinquity between the everyday and the extraordinary. What is it that unites all such acts? I suggest it is the absence of calculation, that arithmetic of debits and credits which we make continually in both small and important matters. And it is right that we should calculate; much of the upbringing of children consists of cultivating the habit of assessment of risks and benefits so that it becomes second nature. All of that is vital for the good. How then can the putting-aside of such calculation have anything praiseworthy about it?

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[473] Lawrence A. Blum, 'Iris Murdoch and the Domain of the Moral', *Philosophical Studies,* 50 (1986) 343-367, p. 362.

If we focus once again on its Christian origins, supererogation requires us to put aside our calculative defences, just as the Good Samaritan let carefulness go by while he attended to the wounded man at the roadside. This state is found in Psalm 22 which describes our uttermost weakness and vulnerability.[474] It is the willingness to expose ourselves in this way, perhaps getting it wrong and putting ourselves at risk of shame, which makes supererogation both a mystery and a challenge to our sense of self. That in turn suggests some willingness for us to divest ourselves of our self-identity and to become amalgamated into some bigger whole. We normally work with a prudent sense of attending to others while looking after ourselves, but at times we can grow tired of tit-for-tat rationality. Supererogation suggests the presence in us of 'a bold and noble Faith' which bypasses rationality, or rather shows rationality and mystery to be in perpetually uneasy relationship.[475] This faith is manifested by the recognition of our vulnerability. Doctors might be wary of extending themselves beyond duty, however they might define it, because of fears of not living up to some ideal. In fact, supererogation is about sharing in the vulnerability of patients, not in demonstrating some ideal of strength and resolution. Once again we come back to the Sermon on the Mount rather than the Ten Commandments, for strength and resolution separate us from the sick. The mystery of Christian supererogation is found in the *absence* of a final search for ideal perfection. We do not have to torment ourselves with thoughts of 'if this were the case then I would do that', rather we can confidently say, 'I have been justified in Christ therefore I can do that', following in his footsteps. I believe this emphasis brings supererogatory acts within the range of what is possible and desirable for Christians. Supererogation is thus a continual invitation for Christians to set off on pilgrimage, not to historic sites at home and abroad, but within ourselves, overcoming our egoism and self regard. And yet this invitation is also offered to doctors without religious faith. This is because supererogation originates in Christian theology but its practice can be adopted regardless of faith or belief.

Pilgrims took on risks and dangers when travelling far from home, and there was no special bargain to be struck with God that the pilgrim's good intention would act as a

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474 To see a patient's dry tongue stuck firmly to the roof of the mouth because of dehydration is extremely pitiful.

475 'As for those wingy Mysteries in Divinity, and airy subtleties in Religion, which have unhing'd the brains of better heads, they never stretched the *Pia Mater* of mine'. Browne, 10-11.

talisman against illness. Doctors remain vulnerable when they are attending patients, especially those with infectious diseases; indeed, it is right that they should accept that vulnerability with a good grace, taking only reasonable steps to avoid infection, for not even complete protection guarantees freedom from ill-health. Robert Song writes of the 'Christian imperative to be vulnerable to the intractability of the world'.[476] It is by sharing vulnerability that we show our strength of character and are able to attend to sick patients with intense focus and application, free from the distracting worry about our own health. We are then more likely to see a dovetailing of 'moral obligation and spiritual change'. This entails seeing our moral obligations to others in a new light, not pushed to one side by our professional duties. What I am finally suggesting here is that doctors might come to work in a manner showing a seamless joining of obligations and professional duties; indeed transcending all notions of duty and obligation to do their work in a new way.

I have witnessed this state in some doctors I have worked with; what was notable was how they appeared to work very hard but without any sense of strain. This is not to say that their work was not demanding and tiring, perhaps draining at times, but they seemed to be free from the irksome nature of working against the grain. Inclination, duty, obligation, disposition, all flowed in the same direction: it was a pleasure to work with them because of their good grace. There were times when I was able to access this state of grace, if only for short periods, and to work in this enlightened manner. Whether or not the doctors I admired were fortunate enough to be born with infused grace, or acquired grace through application and attitudinal change is perhaps impossible to say.

It might be objected that this focus on our moral obligations deflects doctors from their proper concern which lies in the application of their medical gaze: patients want to be cured of their illness, not to be bathed in celestial light. What I think is important here is for doctors to see their professional duties in the light of their moral obligations, a synergistic pushing and pulling which we found in the *vis a fronte* and

476 Robert Song, 'Wisdom as the End of Morality', in Stephen C. Barton (ed.) *Where Shall Wisdom be Found*, (Edinburgh: T&T Clark, 1999), 305.

vis a tergo of the heart contractions. When we are '*really* looking' at patients we see them with all our faculties, not just a specialised part of our being.[477]

Finally in this section, how can we distinguish between the second and third models of supererogation, apart from the element of sacrifice? The absence of a search for the ideal links in with Winnicott's work, whose 1940's radio talks were entitled, '*The Ordinary Devoted Mother'.*[478] He discerned that the mother and child are not psychologically separate but united into a whole, a mother-child person, especially during breast-feeding. We can discern something similar in what we might call, *The Ordinary Devoted Doctor,* perhaps most noticeable in those doctors with a strong sense of vocation. I suggest that Dr Chavasse showed this quality in abundance, continually giving of himself into a psychological fusion with the wounded soldiers he attended. His work included the 'ordinary' work of an army doctor, such as the amputation of a soldier's arm on the battlefield, performed in conditions which were both matter-of-fact and devotional.[479]

'Devotion' can be manifested in differing ways, as illustrated in the second and third models. An important distinction between Dr Chavasse and doctors who demonstrate the third model lies in this quality of devotion. Dr Chavasse showed this devotion intensely, and many anecdotes of his military service illustrate this. His devotion amounted to a psychological fusion with his patients, by which I mean he demonstrated intense empathy and stood alongside them, with sacrificial service to others being the hallmark of his actions.

Devotion in the third model amounts more to a social and emotional cohesion; they are intensely engaged with patients but do not seek the psychological fusion of the second model. A good example of this is illustrated in the work of Dr John Sassall, a GP in The Forest of Dean. The author, John Berger, followed the doctor for six weeks and wrote an extended essay on him, first published in 1967 with photographs

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477 Robin Downie has thrown light on how we can combine different 'modes of attention' at one and the same time. Robin Downie, *Quality of Life: a Post-Pandemic Philosophy of Medicine* (Exeter: Imprint Academic, 2021).

478 Donald W. Winnicott, *The Collected Works of D. W. Winnicott, vol 7, 1964-1966* ed. by Lesley Caldwell and Helen Taylor Robinson (Oxford: Oxford University Press, 2016)

479 'We had to do everything by the light of an electric torch and when we got a stretcher it took us two hours to get him out of the wood. ' Clayton, 163.

by Jean Mohr.[480] *A Fortunate Man: The Story of a Country Doctor* won excellent reviews, deeply expressed, and was handed out by senior doctors to trainees as a model of good practice. It is hard to pinpoint exactly why the book is so moving, but the doctor's devotion to his patients is clear. It is the *ordinary* nature of the doctor's work, and the long-drawn out nature of his service, which are so striking. This included attending nearly all births and deaths of his patients, recognising their anguish, and providing hour-long appointments with patients in the evenings after dinner to provide psychoanalysis. I put forward Dr Sassall as an example of the tacit good that a doctor can do, running alongside the obvious diagnosis and treatment of disease. He was continually with his patients, nearly always out of the surgery premises doing home-visits; his goodness was embodied in him, and he carried this presence with him, his goodness preceding his entry into the bedroom of the sick. His physical presence, as much as his wisdom, gave his patients 'the grace to say the unsayable'.[481] The photographs of patients in the book are not annotated but they hint at this diffidence being overcome and distress falling away. Unfortunately, even at the time of publication his single-handed style of medical practice was in decline, with group practices on the rise, and the more recent disinclination of doctors to offer home-visits indicates, I believe, a great loss to patients and doctors.

The anecdote described above, about how Iris Murdoch got it wrong with Martha Nussbaum, shows how easily we can miss the mark when trying to pay attention to others. Perhaps we are trying too hard when we *'really* pay attention' to others; rather it needs to be part of our way of being, a habitus which is practised without self-consciousness. Dr Sassall showed this, with a sustained level of attention to patients over many years, displaying the completely unglamorous, ordinary work of a devoted doctor who was profoundly attuned to his patients.

6.11 The Embodiment of Supererogation as Secular Sanctity

I now describe two doctors who manifested this third model more publicly and so are better known than Dr Sassall. They both demonstrated courage and determination in

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480 John Berger, Jean Mohr, *A Fortunate Man: The Story of a Country Doctor* (Edinburgh: Canongate Books, 2016). He seems to have been embedded in the landscape of his patients, reminiscent of the characters in Hardy's novel, *The Return of the Native.* They are embedded in the landscape of Egdon Heath which plays its own part in the drama.

481 Song, 295-306.

that they travelled abroad in the fulfilment of service to others. Hauerwas might have described them as 'bending life towards God', in his belief that the Christian life is based on activity in socially embodied ways of being, believing and acting.[482] In modern usage we could say they 'leaned in towards others'.

6.11.1 Dr Ludwig Guttmann (1899-1980): 'A Lofty Kind of Life'

A doctor who clearly did lean in towards patients was Dr Ludwig Guttmann, founder of the National Spinal Injuries Centre at Stoke Mandeville Hospital, and famous as the pioneer of the Paralympic Games; the games began in the hospital grounds in 1948, on the same day as the London Olympic Games.[483] In the context of supererogation the following points are salient:

i) While a senior doctor in Germany he admitted both Jewish and non-Jewish patients to his hospital after *Kristallnacht* (9 November 1938), and justified the prohibited admission of Jews when challenged by the Gestapo, thus preventing many deportations to concentration camps.
ii) After escaping from Germany he worked as a neurologist in England and overcame the opposition of his colleagues to push forward his ideas on rehabilitation. He believed it was wrong to leave patients to languish without active treatment.
iii) He did not see the status quo as a barrier to his duties, but pushed into new territory.

His duty and supererogation combined seamlessly, and in the context of the Second World War his new ideas were like aerial mines dropped from a great height, with an enormous lateral thrust of goodness: although he could not get the injured back in the field, the good he achieved was a counterbalance to the evil which he had witnessed first-hand. He brought the opportunity of a second flowering for injured patients. His work was not some sort of stepping stone to salvation, as with the counsels of the *Beyond Duty* model, rather it was to find again some sort of decency on earth, and this took the form of an imaginative and engaged care for his patients. His dutiful work

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482 Michael Cartwright, 'A Reader's Guide', in Hauerwas, 637.
483 Susan Goodman, *Spirit of Stoke Mandeville: The Story of Sir Ludwig Guttmann* (London: Collins, 1986).

and his supererogation in organising the Games went hand in hand. Never before was the *telos* of medicine so clearly pursued.

For the servicemen who undertook such activities a return to civilian life with paid employment was eventually possible. He drove work forward on many fronts: improved wheelchair design; new thinking in physiotherapy; specialist hospital and community care units; the invention of new catheters which caused less irritation; dropped roadside kerbs to make crossing the road easier. There was a slow process of improvement in medical and technical matters, with changes in social attitudes essential to keep the momentum going. Above all, as we see in the Paralympic Games, the sequestration of 'cripples' in long-stay hospitals was overcome, and we now welcome and expect former patients to have access and acceptance just about wherever they wish to go, including admission to medical schools.

6.11.2 Dr John Beavis

Dr John Beavis (1940-2018) was a doctor who achieved renown for his volunteering to help in war zones.[484] He was a surgeon working for the NHS when he had to take retirement on medical grounds: a serious heart condition was diagnosed and he was judged to be unfit to continue. He retired, but then found himself drawn towards volunteering abroad, in Bosnia and elsewhere. He trained over 2000 doctors in emergency surgical techniques which have saved thousands of lives, and he has organised relief behind the scenes too. He was decorated and honoured in his lifetime and his charitable foundation continues.

His supererogatory work is clear: he had no obligation to volunteer, especially for work abroad; he was under no contractual obligation; his work was clearly of benefit to others; his emphasis on training junior surgeons shows continuity of service to others. All this was beyond what might have been normally expected and was done for the benefit of others.

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[484] https://www.the guardian.com/society/2019/jan/16/john-beavis-obituary [accessed 29 March 2022]

It might be said that voluntary work illustrates the third model perfectly, for contractual duty has fallen out of the scene, and the roots of our relationships with others are all that are left to ground us in our service to others. What are those roots? I suggest they include the desire to help others, charitable work, service in all its forms, and, importantly, being helped by others when we are ill.[485] The willingness to be helped is a sign of our mutual dependency and it counters any tendency to superiority or condescension on the doctor's part. We normally think of our duty as being the visible part of our obligations to others, as with the tree trunk enduring the hardships of sun and rain, but here the normally invisible roots are exposed and seen to be the foundation of the matter, for they sustain and nourish our individual life and our lives together. They represent the values we live by and take for granted. John Beavis showed that to perfection by turning his career on its head and working just as hard after retirement as before. The fact that he worked for free after being judged not fit to continue in a contractual way adds piquancy to the situation and points up the naked goodness of his work. This led the way for other retired surgeons to volunteer to teach young doctors in developing countries.

We can interpret supererogation here as finally breaking away from the dutiful base on which it is supposed to be established. There are different ways of seeing this state of detachment: either we think in terms of duty and supererogation simply rolling round each other into a new whole, or we might think of supererogation as being the embodiment and fulfilment of ourselves at our best, the transcendence of duty allowing us to expand and spread goodness over others. Seen in reverse, we could say that this shows that our service to others is in fact limitless, as Levinas suggested, and that we continually separate duty from supererogation in order to save our energies. In a final view of the matter, the boundary between duty and supererogation is transcended, indeed we pass beyond morality itself, an exalted and yet also a

485 'Thus our willingness to be ill and to ask for help, as well as our willingness to be present with the ill, is no special or extraordinary activity but a form of the Christian obligation to be present to one another in and out of pain'. Hauerwas, 'Salvation and Health: Why Medicine Needs the Church' in *The Hauerwas Reader*, 553.

mundane state.[486] We can thus say that the blending of duty and inclination which we witness in colleagues who love, indeed 'live for', their work pushes doctors into the furthest reaches of this process by continually giving up their egoism in the service of others.

Here in the *Supererogation as Secular Sanctity* model we can take these faltering steps towards that cohesion with others, a continual accretion of growth in spiritual wisdom. The further we are on that path the more egoism falls away, and those we serve become of equal worth to ourselves. It must be admitted, however, that egoism continually rears its head, and the open-ended commitment to others which supererogation suggests can be difficult to sustain. The intrusion of egoism into ostensibly supererogatory actions is an important area which will be considered in the next chapter.

6.12 Conclusion

In this chapter I have commended a third model of supererogation and have indicated how it differs from the *Beyond Duty* model and the *Supererogation as Sacrifice* model. I recommend it strongly for doctors who are at all inclined towards this idea of enhanced service to others. It is concerned with opening our hearts to the suffering of others, along with a giving of ourselves in service to care for and sometimes cure patients. It does not involve sacrificial service to others and so can have application to doctors with families and interests outside medicine. I have referred to the philosophy of Murdoch to strengthen the argument, and used case histories to illustrate salient points. There is a danger that we might lose our way when putting supererogation into practice, so in the next chapter I look at problems which might arise, including the harm done when supererogation misfires.

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[486] Mark Wynn, 'Supererogation and the relationship between religious and secular ethics: some perspectives drawn from Thomas Aquinas and John of the Cross. in Cowley (ed.), 163-183. Wynn refers to George Mavrodes's remark that: 'Within some families perhaps . . . people may for a time pass largely beyond morality and live lives of gift and sacrifice'. 178.

7. Chapter Seven: Problems and Pitfalls of Supererogation

7.1 Introduction

I described *Supererogation as Secular Sacrifice* in chapter 6, and I recommended this model for modern doctors. I believe that doctors should take advantage of this rehabilitation, yet there are difficulties in implementing this, indeed there is opposition to the notion of supererogation in medicine, both in principle and in practice.

I describe some of this opposition. I then name and describe three pitfalls for doctors who wish to practise in a supererogatory way. These are: i) uncontrolled egoism, ii) discounting the patient, and iii) wishful thinking. I illustrate these dangerous failings by studying two nineteenth century novels: *Middlemarch* by George Eliot, and *Madame Bovary* by Gustave Flaubert. Both novels are rich in the psychological perception which concerns me here, for both authors show subtlety in descriptions of self-deception, and that is the umbrella term which leads to bad outcomes. I then show how the failures and difficulties of supererogation might be avoided, and I outline a new interpretation of what can be achieved using a theological approach to inform doctors' actions.

7.2 Supererogation and Medicine

Standing back from the person to person encounter of the consultation, and taking a broad brush approach, a variety of doctors and scholars have pointed to the disadvantages of supererogation in medical practice. There is strong disagreement on whether supererogation has any application. An austere, minimal view is given by Robin Downie,[487] who believes that though doctors may sometimes act supererogatorily in their work, it is not a necessary feature, and nor are they behaving altruistically. Those features are just a part of the job description: morality is not an

[487] R. Downie, 'Supererogation and altruism: a comment', *Journal of Medical Ethics,* 28 (2002), 75-76.

intrinsic part of that work, rather it is a feature of an individual doctor's practice. Dr Alan C. McKay rebutted Downie's view:[488] as an anaesthetist, and in light of growing medical scandals, McKay emphasised the 'fiduciary' nature of the doctor-patient relationship, believing that doctors become committed to supererogatory acts because of the open-ended risk to themselves.

Kottow[489] emphasised the dangers of supererogation in practice: his concern was the appearance of 'separatist views' which led doctors to think of themselves in a state outside ordinary moral restraints.[490] He distinguishes between supererogation and altruism, concluding, 'Requiring doctors to be altruistic is dangerous and unfair'.[491] The danger seems to be the ease with which some doctors are so led astray by vanity and hubris that they harm patients unwittingly. Kottow refers to the discussion in the 1980s of the nature of professional morality. There was a debate between Freedman and Martin[492] which centred on whether doctors were properly constrained within ordinary morality or whether the nature of their work brought about special permissions and requirements which superseded ordinary limits. While this aspect has been fully discussed by Heyd, I note that once supererogation moves away from those cases of heroic or self-sacrificial behaviour which seem straightforwardly admirable, then we soon move into borderline areas such as 'personal duties' of kindness or charity, or into murky moral areas such as 'permissive ill-doings'.[493] The attitudinal fault is like that of the skier who goes 'off-piste', something exciting and risky, but the fear in medical practice is that the doctor, dazzled by excitement, might lead the patient into dangerous territory.

Susan Wolf [494] makes the point that people who devote their lives to good works at cost to themselves would in fact be hard to live with; they would be lacking that broad

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488 A. C. McKay, 'Supererogation and the profession of medicine', *Journal of Medical Ethics,* 28 (2002), 70-73.

489 Michael Kottow, 'Against the magnanimous in medical ethics', *Journal of Medical Ethics,* 16 (1990), 124-128.

490 Kottow, 124.

491 Kottow, 127.

492 B. Freedman, 'A meta-ethics for professional morality', *Ethics,* 89 (1978), 1-19; B. Freedman, 'What really makes professional morality different: responses to Martin', *Ethics,* 91 (1981), 626-630; M.W. Martin, 'Rights and the meta-ethics of professional morality', *Ethics,* 91 (1981), 619-625.

493 Heyd, 129. Lingering too long in a restaurant while others are waiting for a table is an example. In order to be 'permissible' then such acts need to be only venial sins.

494 Susan Wolf, 'Moral Saints', *Journal of Philosophy,* 79 (8) (1982), 419-39.

range of interests which makes for well-rounded individuals. She claims that moral saints would have 'strangely barren' lives.[495] At a more abstract level she shows that the division into acts which can be described as duty, versus those which are desirable but optional, would be difficult to define, and she notes the lack of 'specific principles' to separate them. She does see the need for 'some conception of supererogation' if we are to account for the fact that non-moral activities can be just as important for us as moral ones, something especially called for when our work has a vocational aspect.

Wolf's comments are of importance for any introduction of supererogatory ideas into medical practice. Firstly, as stated elsewhere in this thesis, no existing philosophical theory is going to satisfy the demands of doctors for guidance on how to put such ideas into practice; indeed the ad hoc nature of such attempts is likely to count against any well thought out rationale which medical students and junior doctors might request.[496] Doctors are looking for a deeper foundation.

Secondly, also of concern at this interface would be the idea that doctors with a sense of vocation might be under greater obligation to perform acts of supererogation than those who simply meet contractual requirements. The limits of duty are at the centre of this issue. Archer addresses the relationship between supererogation and sacrifice, and writes,

> The question of whether moral exemplars should face higher moral standards than other people is both interesting and complicated. We should prefer an account of the limits of duty that does not supply a simple response to this difficult issue.[497]

Finally in this section, the interface between medical practice and philosophy comes into focus over the question of impartiality. There is tension between seeing the patient as an exemplar of a group rather than an individual in need of help. Albert

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495 'The way in which morality, unlike other possible goals, is apt to dominate is particularly disturbing, for it seems to require either the lack or the denial of the existence of an identifiable, personal self" (Wolf, p.424) is at the heart of her objections,

496 'Deontological, consequentialist and virtue based approaches can all be perverted if not settled on a foundation of natural law which recognises the primal teleology of "do good and avoid evil".' Stephen J, Pope, 'Reason and Natural Law', in *The Oxford Handbook of Theological Ethics,* ed. by Gilbert Meilander and William Werpehowski (Oxford: Oxford University Press, 2007), 150.

497 Alfred Archer, 'Supererogation, Sacrifice and the Limits of Duty', *Southern Journal of Philosophy,* 54 (2016), 333-354 (p.350).

Musshcenga[498] describes how impartiality has a respectable philosophical underpinning, especially valued in the mid-twentieth century (e.g., by G. J. Warnock, but this was undermined by Williams in the 1970s). Impartiality's 'God-like' point of view now seems both implausible and too distant from the patient; it can lead to the dangers of condescension towards the patient, as we saw in *Mrs Dalloway* in Chapter 4. The fault here is thinking that we can stay aloof from the poignancy of patients' suffering, while I claim that we *should* stay alive to these painful impressions, using good judgement about how best to react. Unless disciplined, our responses might appear to be partial to certain individuals yet neglectful of others. Such partiality would conflict with justice as fairness, though it is clear that if doctors were to try to work in anything like a 'blind', random way, then the very thing that makes such responses generous to others, that sense of being moved by the individual before us, would be lost. We would like to think of doctors having sensibility, or a repertoire of responses. If we think of Archer's request that simple solutions are to be avoided, then we can translate this into a varying responsiveness, tailored to the individual patient.

I believe that supererogation does have application in medical practice for it has the potential to enrich both patients' and doctors' lives. The enduring legacy of the Beyond Duty model was to show that acts might not be obligatory but they nevertheless can remain highly desirable. I now describe how doctors can get things badly wrong if they do not take care to approach supererogation in a wise and appropriate manner. First and foremost, doctors should pause and ask themselves, 'Who benefits from what I have in mind?'

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498 Albert W. Musschenga, 'The Debate on Impartiality: An Introduction', *Ethical Theory and Moral Practice,* 8 (2005), 1-10. G. J. Warnock emphasised the value of impartiality to counter our over-focussed personal concerns and to expand our 'limited sympathies', but Bernard Williams countered with his criticism of the 'God-like point of view' and how wrong it was for people to distance themselves from 'everything that is essential to their identity'. G.J. Warnock, *The Object of Morality* (London: Methuen, 1971); Bernard Williams, *Moral Luck* (Cambridge: Cambridge University Press, 1981), 1-19.
Musschenga writes that 'any particular moral motive can take unhealthy forms' (p.9).

7.3 Two Literary Examples

7.3.1 Uncontrolled Egoism: George Eliot and *Middlemarch* (1871-1872)

Let us now look at two nineteenth century novels: *Middlemarch* by George Eliot, and *Madame Bovary* by Gustave Flaubert. They are linked by the authors' intense perception,[499] showing not just what went wrong but why the failures occurred. *Middlemarch* is of especial interest because it illustrates the two varieties of supererogation: the one found in a professional setting, the other found outside any notion of contractual requirement. I shall present these novels as factual texts despite the complex concerns of scholars who might see such a reading as a naive approach.[500] Three common pitfalls are revealed: uncontrolled egoism, losing sight of the patient, and wishful thinking. All three might be described as showing variations of a surfeit of self-directed sensibility, a name reflecting both the recognition of sensibility in novels of the eighteenth century, its vigorous rebuttal by critics of the period, and its scholarly treatment in recent times.[501] More prosaically, these come under the modern heading of self-deception.

Middlemarch is *the* medical novel of the nineteenth century canon of English literature. It is characterised by psychological penetration and an attention to medical accuracy which the surgeon, Sir James Paget (1814-1899), praised highly.[502] Eliot enquires into doctors' motivations and projections of themselves onto the world, with patients as their raw material.

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499 'In her cool notation of apparently insignificant detail, George Eliot is the equal of Flaubert in *Madame Bovary'.* W. J. Harvey, 'Introduction' to George Eliot, *Middlemarch* (Harmondsworth: Penguin, 1977), 19.

500 Lawrence Rothfield, *Vital Signs: Medical Realism in Nineteenth Century Fiction* (Princeton: Princeton University Press, 1992).

501 The cultural historian G. S. Rousseau has studied both sides of the issue.

502 Felicia Bonaparte, 'Introduction' to George Eliot, *Middlemarch,* (Oxford: Oxford University Press, 2008), xxxv. Sir James Paget described a disease of the bones (Paget's disease) and a serious disease of the breast (Paget's disease of the nipple), terms which are still in common use.

Lydgate arrives as a young doctor who has studied in London, Edinburgh and Paris. He 'was something rather more uncommon than any general practitioner in Middlemarch',[503] but the seeds of his difficulties are hinted at early on. Interested in science, indeed ambitious and impatient, he hoped that 'he might work out the proof of an anatomical conception, and make a link in the chain of discovery'.[504] Furthermore he had 'noble intention and sympathy', but mixed with conceit: 'Lydgate's conceit was of the arrogant sort, never simpering, never impertinent, but massive in its claims and benevolently contemptuous'.[505] He thinks himself above the petty concerns of *Middlemarch* life, disdaining to earn fees by dispensing medicines and making enemies as a result; he also exalts science as a 'culture of which country practitioners have usually no more notion than the man in the moon'.[506] His ambition for scientific discovery leaves him vulnerable to criticism, and he is disdainful of that. He is suspected of wanting to dissect corpses for the purpose of anatomical discoveries into the nature of 'primitive tissue'. Furthermore, he neglects his private patients because of work at the new hospital where he is pursuing research into cholera, with hopes of founding a medical school in Middlemarch. He is tender hearted, falls in love with Rosamund Vincy and marries her, but then becomes aware of how self-centred she is. They live beyond their means.

Lydgate is a good doctor, shown by his desire for health improvements in the town and by careful attendance on his patients, but his intervention causes offence to another doctor in the town, leaving resentment in the air, an additional example of his unconcern with prevailing customs and practices. This is an example of the 'conceit' mentioned above.

Lydgate's readiness to be of service is shown by his attendance on Raffles, a disreputable character, at the house of Bulstrode, a prominent banker. Raffles knows a secret about Bulstrode which will cause scandal if revealed. Raffles is suffering from delirium tremens, and opium is prescribed by Lydgate but this treatment is subverted by Bulstrode. Raffles dies in the night; Lydgate is suspicious but dares not ask further questions because of his financial obligation to Bulstrode. Lydgate is in

503 George Eliot, *Middlemarch* (Oxford: Oxford University Press, 1986), 133.
504 *Middlemarch* (Oxford), 137.
505 *Middlemarch* (Oxford), 149.
506 *Middlemarch* (Oxford), 117.

turn subject to gossip and rumours after his kindness in coming to the aid of Bulstrode who is on the point of collapse in a public meeting. This failure to enquire further into the death of Raffles reflects badly on both his sense of professional duty and moral obligation.

Lydgate's story runs alongside that of Dorothea, an idealistic young woman who is disdainful of mercenary ambitions. She marries the elderly Casaubon who is pedantically and selfishly labouring on a grand work of history, the 'Key to all the Mythologies'. She wishes to help him in his research, but Ladislaw, Casaubon's nephew, points out to Dorothea that Casaubon's work is out of date, having been superseded by German scholars. Even so, she attends to her work as his assistant and supports her husband as best she can. She is charitable and supports the hospital financially.

The novel is of especial interest because it demonstrates the variety of supererogation found outside professional duties. The novel is complex and rich in characterisation, so there is no black-and-white division between these examples of supererogation, but Dorothea demonstrates this wider sense when she visits Lydgate and his wife, Rosamund, after his unwise involvement with Bulstrode. Lydgates's reputation has plummeted and he is emotionally crushed. Dorothea's visit can be seen as supererogatory in this *ought to* mode, for while she has no formal duty to Lydgate she feels compelled to reach out to him. She transcends her grief for her husband's death and finds herself anxious to help:

> The idea of some active good within her reach 'haunted her like a passion' and another's need having once come to her as a distinct image, preoccupied her desire with the yearning to give relief, and made her own ease tasteless.[507]

Furthermore she transcends her social position within the community of Middlemarch:

> She was full of confident hope about this interview with Lydgate, never heeding what was said of his personal reserve; never heeding

[507] *Middlemarch* (Oxford), 716.

> that she was a very young woman. Nothing could have seemed more irrelevant to Dorothea than insistance on her youth and sex when she was moved to show her human fellowship.[508]

This shows another important aspect of supererogation - the cost incurred - for Dorothea risks her reputation by entering into the personal life of her doctor. This alternative view of the concept was described by Feinberg in his criticism of Urmson's essay, discussed in chapter 1**,** and has been developed by Swinburne. This concerns 'final human worth, all things considered'. and is made up of those things which we feel we *ought* to do but are not *obliged* to do. This cleft between *ought to* and *obliged to* was identified by Stephen Toulmin,[509] and was recently developed by Michael Ferry.[510] Keith Ansell-Pearson has also described 'a higher calling of life beyond obligation'.[511] One can envisage this aspect, the world of '*ought to'*, as a vast penumbra around the more easily visible core of '*obliged to'*, and in contrast to the world of contractual duty, this more nebulous world of '*ought to'* has long since been recognised by novelists.[512]

7.3.2 Beyond Duty or Transcending Duty

Conceptual conservatives might object that as there is no formal duty of Dorothea to Lydgate and his wife then her interventions should not be thought of as supererogatory acts. This sense of a hard boundary between duty and supererogation is something we might wish to promote, for that would give clarity to situations where duties need to be satisfied conscientiously. We could therefore think of supererogation as having a formal, limited sense, easily demarcated by a hard sense of duty, or we could see supererogation as a vague concept which is both difficult to

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508 *Middlemarch* (Oxford), 716.

509 Stephen Edelston Toulmin, *An Examination of the Place of Reason in Ethics* (Cambridge: Cambridge University Press, 1964), 147.

510 'There is nothing odd, let alone incoherent, about saying, "Of course, you probably ought to give even more, but I don't see that you're obligated to".' Michael Ferry, 'Beyond Obligation: Reasons and Supererogation', Christopher Cowley, (ed.) *Supererogation, Royal Institute of Philosophy Supplement: 77* (Cambridge, Cambridge University Press: 2015), 49-65. p.63.

511 Keith Ansell-Pearson, 'Beyond Obligation? Jean-Marie Guyau on Life and Ethics', in Cowley, 207-225.

512 e.g., *Ruth*, Mrs Gaskell's novel, portrays a young woman who is wronged by a prosperous man. Later she meets him again and, though owing him nothing, nurses him through a cholera epidemic. She dies of the infection.

define and describe and which is more concerned with giving of oneself in a generous way. This latter aspect, opened up for us by Feinberg, would be the world where we do not wish to be confined by contractual duties, finding such things irksome.

This giving of oneself, stemming from generosity of heart, is shown by Dorothea, for by going to see Rosamund, and trying to persuade her of Lydgate's innocence, she is putting at risk her own relationship with Ladislaw whom she loves but whom she fears is in love with Rosamund. This second aspect of supererogation, displayed by Dorothea, acts as a counterpoint to Lydgate's supererogation, displayed in his altruistic ambitions, but which is undermined by his lack of diplomacy. The image of a patient extending herself in this way to help her doctor and his wife contrasts with Lydgate's earlier attempts to lead Middlemarch medicine into a scientific future:

> But it is given to us sometimes even in our everyday life to witness the saving influence of a noble nature, the divine efficacy of rescue that may lie in a self-subduing act of fellowship. If Dorothea, after her night's anguish, had not taken that walk to Rosamund - why, she perhaps would have been a woman who gained a higher character for discretion, but it would certainly not have been as well for those three who were on one hearth in Lydgate's house at half-past seven that evening.[513]

Dorothea's rise and 'divine' rescue of others, a noble action, is contrasted with Lydgate's fall, here shown as a retreat into the safer world of professional duty:

> "I am come back in my quality of doctor," he said. "After I went away, I was haunted by two pale faces: Mrs Casaubon looked as much in need of care as you, Rosy. And I thought that I had not done my duty in leaving you together; so when I had been to Coleman's I came home again."[514]

Lydgate has retreated from the role of husband, who does not know what to say, into the professional role of doctor who falls back upon stale habits of speech. He failed to bring about his ambitions because he left his patients behind. He neglected to look after himself; importantly, in this respect, he felt he had failed both as a person and as a doctor, and this contrasts with Heyd's idea,[515] expressed in Chapter 1, that

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513 *Middlemarch* (Oxford), 754.
514 *Middlemarch* (Oxford), 751.
515 Heyd gives the example of a doctor who 'goes to a plague-stricken city', praising him for his action, not as a doctor, but '*as a man* (who happens to have a highly relevant skill)'. Heyd, 135.

supererogation is a property of the person, not of the agent in a professional role. In this respect I would prefer to think of people as whole beings, not separable into parts; indeed the idea of 'role-playing' is false and leads to incoherence in our presentation of ourselves.[516] Virtues and vices belong to individuals and cannot be diffused amongst the profession as a whole. In this regard it has been said by Michael Davis, a scholar of Eliot's novels, that,

> At the heart of *Middlemarch* is a profound sense of the difficulty of putting ideals into practice in the world. This difficulty is inherent in the constraints which society and culture place on individuals, but it is also, emphatically, intrinsic to the tensions and contradictions which go to make up the inner life of each individual - at once inseparable, and radically separate from external forces - in that society.[517]

Lydgate was a scientific idealist who was disdainful of conventions. He is humane, but he regards science as the way forward, so his is a reductive humanity, refashioning the treatment of patients with science as the chosen method. We can say that his ambition is his Achilles' heel, for it falsely elevates him above mundane but important considerations. At the heart of both duty and supererogation is the paradox that we cannot look after others if we fail to look after ourselves.[518] Dorothea's humanity is not reductive; she gives of herself without using science as a key, so that is a face-to-face humanity. She is free from the taint of triangular relationships which besets Lydgate's attempts, for his loyalty seems primarily to medical science, with patients occupying some dependant relationship. Dorothea's attempt to support Lydgate and Rosamund succeeds, pointing to the complexity of doctor-patient relationships; it is not a one way traffic but the coming and going of people involved in a moral and professional relationship with each other.

Both Lydgate and Dorothea have supererogatory ambitions which are thwarted: Lydgate wishes to establish a medical school and do research into disease; Dorothea

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516 'It is the grandest profession in the world, Rosamund,' said Lydgate, gravely. 'And to say that you love me without loving the medical man in me, is the same sort of thing as to say that you like eating a peach but don't like its flavour.' *Middlemarch* (Oxford), 430.

517 Michael Davis, *George Eliot and Nineteenth-Century Psychology* (Aldershot: Ashgate, 2006), 103.

518 In case of loss of pressure on aircraft parents are told to fit their own oxygen masks before attending to their children.

wishes to build 'a great many good cottages' after her husband's death.[519] Both lose heavily: Lydgate loses his reputation and practice; Dorothea loses her deceased husband's estate when she marries Ladislaw against the terms of his will. She is willing to put her reputation at risk for the sake of helping Lydgate and his wife, Rosamund, and she brings about some reconciliation between them. Lydgate is reduced by his loss to settle elsewhere for 'an excellent practice', 'but he always regarded himself as a failure'. His desire for improvement of the medical world in Middlemarch is fine and noble, if tainted by 'conceit', but ill fortune carries the day. Dorothea is also ambitious but seems able to make better adjustments to her loss. She undergoes a more subtle change, and the final paragraph of the novel dwells on her 'finely-touched spirit', noting that 'the effect of her being on those around her was incalculably diffusive'.[520] Dorothea's worldly ambitions are lost (something which might have been in Eliot's mind when she wrote the Preface to the novel),[521] but there is a charitable transcendence of her losses and a demonstration, I suggest, of the 'final human worth, all things considered' described by Feinberg in chapter **1**.

The narrative of Middlemarch is engaging enough, but in addition we have the philosophical underpinning of George Eliot to deepen our interest. Jenny Uglow, a scholar of Eliot, has written, that,

> Throughout her life she sought to formulate principles of belief which would satisfy both her desire for sympathy with others and her intellectual insistence on logic and evidence.[522]

and these words could stand as a motto for a doctor's behaviour, founded on sympathetic application of belief based on evidence. We think of medicine as focussed on scientific evidence, while going beyond duty is perhaps more indicative of our sympathy with others, especially with those who suffer before us.[523] The difficulties of this dual approach, of finding a balance between the demands of duty and the wish to reach beyond ourselves to help others, are expressed in the novel;

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519 *Middlemarch* (Oxford), 518

520 Middlemarch (Oxford), 785

521 'Here and there is born a Saint Theresa, foundress of nothing, whose loving heart-beats and sobs after an unattained goodness tremble off and are dispersed among hindrances, instead of centring in some long-recognizable deed.' *Middlemarch* (Oxford), 4

522 Jenny Uglow, 'Introduction' in George Eliot, *Felix Holt* (London: Pan, 1978), 7.

523 Hauerwas claims 'that medicine is first of all pledged to be nothing more than a human presence in the face of suffering'. Hauerwas, 'Salvation and Health', 553.

furthermore the difficulty of putting supererogation into practice is compounded by our composite nature, being both 'inseparable' and 'radically separate' from those around us. Lydgate, in his conceit, forgot that he too was inseparable from professional and societal forces. In this one novel, at least, the contractual limits between doctor and patient contrast with the qualities shown by Dorothea who is outside any professional role. One might say that supererogation between doctor and patient, based on duty and obligation, is in fact a subset of the wider generosity which we can display independently of contractual obligations and which is tied up with the broader question of 'How should I live'.[524]

I conclude this section by claiming that supererogation in a professional context falls short of the whole range of obligations which we have one to another. Furthermore, Lydgate's fate emphasises that professional duty needs to be glued together with moral obligations if we are to succeed in being of sustained professional use within the wider context of a life well lived.

7.3.3 Dualisms and Triads

Eliot illustrates the choices open to Lydgate, but we can see these choices not as a simple either/or dualism but as a continual coming and going. The busyness of a doctor's life reflects a dialectic; there is a back and forth about Lydgate, an ambivalence which contrasts his morning briskness with evening fatigue. This notion of ambivalence in Christianity comes from the theologian, H. Richard Niebuhr (1894-1962), described by D. M. Yeager, who found that Christ did not simply rise to heaven after death but came back to earth: much as he loved the Father he loved mankind too. Yeager calls this the 'doubleness' of the Christian calling, and he quotes Niebuhr,

[524] This distinction parallels the question of whether ethics is a subset of morality or vice versa. R. S. Downie, 'Ethics and Morality' in *The Oxford Companion to Philosophy,* ed. by Ted Honderich (Oxford: Oxford University Press, 2005), 271.

> We are 'forever being challenged to abandon all things for the sake of God; and forever being sent back into the world to teach and practise all the things that have been commanded'. [525]

The dualism for doctors is found in the continual tension between seeking rest and refreshment, and enjoying a good living, versus going into the world to practise medicine for the sake of others.

This is a demonstration of how the blurring of supererogation and duty could change practice for the benefit of all, and I also offer it as an example of the 'doubleness' described by Niebuhr where the work devoted to medical research, requiring time and energy beyond the day's work, brings benefit to patients as well as prestige to the doctor. It might be claimed that seeing the 'doubleness' of the Christian calling in doctors of the highest reputation is false, not simply in imagining such doctors following a monastic life of self-sacrifice, but in imagining that they are abandoning the world for the sake of God. This points to the importance, which is at the heart of this thesis, of the motivation of doctors who practise supererogation in their work, and this is not just a concern for Christians but for secular doctors also, especially in view of my interpretation of supererogation arising not from a sense of duty but from generosity. Here I differ from Heyd who makes a clear distinction between motive and intention, and while he claims that supererogatory actions do not have to be accompanied by 'high-minded motives' I believe that intention and motive should not be separated in the medical context.[526] If it were the case that a doctor had undertaken exhaustive research with the intention of curing patients, but whose motive was bad, then we might think that any successful results would have been obtained at the price of loss of integrity. *Supererogation as Secular Sanctity* does point to the close proximity of ordinary behaviour and noble motivation, and that *rapprochement* is something I wish to promote in everyday medical practice, something which can be promoted independently of religious belief.

I agree that motive and intention are difficult to discern in medical case histories, and this lends further support to my literary approach; indeed it is only in novels where

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[525] D.M. Yeager, 'H. Richard Niebuhr's *Christ and Culture*' in Gilbert Meilaender and William Werpehowski, *The Oxford Handbook of Theological Ethics,* (Oxford: University Press, 2007), 466-486, p. 471.

[526] Heyd, 137.

the psychological texture of life is examined in detail.[527] We need to know what is the state of mind of the doctor we are about to praise or condemn. An example concerns the trials of polio vaccine in the 1940s: the intention was praiseworthy, but the race to produce vaccines by rival companies leads us to question the motives of the players involved.[528] We want to know just how finely balanced are the opposing forces: service to others on the one hand, self promotion on the other. The value of *Middlemarch* lies in showing the complexity of such a balancing act, with others holding the scales in which such forces are weighed: it is *their* judgements which govern the outcome, not the self-satisfaction of the doctors themselves.

7.3.4 Self-awareness

I have emphasised the need for awareness of our motives, and although these can be hidden from our view, yet I believe doctors should continually reflect on them. In fact I suggest that this should be added to the list devised by Heyd of the four necessary qualities of supererogation. The fourth requirement states that 'it is done voluntarily for the sake of someone else's good, and is thus meritorious'.[529] This is a difficult requirement for, as with Lydgate, someone else's good is rarely purely achieved and might be accompanied by self-regarding motives. This view is strongly at odds with Heyd who emphasises that his criteria point to the *action* of agents and not to states of affair which should exist or to 'traits of character or virtues that a person ought to have'.[530] He emphasises action based on duty; I emphasise action based on good intention and virtuous motive, for without these criteria actions might appear to be praiseworthy to outward show, but could be undermined by self-regarding attitudes. If this were shown to be the case after the event then our estimation of the agent would suffer as a result.

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527 'For any detailed description of the complexity of human nature, of the insurgence of instinct in the garb of reason, of the multifarious play of the social environment in the individual ego, and of the individual ego on the social environment, I had to turn to the novelists and the poets' From Beatrice Webb, *My Apprenticeship* (London: Longmans, Green & Co: 1946), p.119; quoted in *Middlemarch* (Penguin), 20.

528 Outbreaks of polio in those children who had been vaccinated pointed to the lack of care in deactivating the virus before manufacture.

529 Heyd, 115.

530 Heyd, 115.

7.3.5 Losing Sight of the Patient and Self Deception: Gustave Flaubert and *Madame Bovary* (1856-1857)

An example of how self-deception can lead to disaster is shown in *Madame Bovary*. It throws light on how we come to define 'someone else's good'. Charles Bovary arrives in a provincial town, sets himself up as a doctor, and marries the daughter of one of his patients. His wife soon becomes disenchanted with the smallness of their life and finds consolation in affairs. Bovary, dejected and dispirited, is encouraged by his wife, and by Homais, the town's ambitious pharmacist, to perform an operation for clubfoot on Hippolyte, an ostler at the inn. Madame Bovary sees the operation as a means of restoring her husband's standing in her eyes, and the pharmacist seeks vicarious glory for himself and a boost to the town's reputation. The pharmacist manipulates the patient to give consent. Having no experience in such matters, but wishing to impress his wife, Bovary 'lets himself be persuaded', reads the surgical books, and goes ahead with the operation. Infection sets in shortly afterwards, the leg becomes gangrenous, and Hippolyte's life is saved only by an amputation through the thigh performed by a surgeon brought in from the city. Madame Bovary is so disgusted by her husband's failure that she returns to her former lover. Things later unravel further, she is abandoned by her lover and takes her life by swallowing poison obtained through deception from the pharmacy.

Madame Bovary can be analysed in terms of a doctor's duty and virtues. The lack of virtues is apparent in the characters in the novel; they all seem unaware of how they are acting in their interactions with others. Jean Porter emphasises the need for 'reflection' in the light of the cardinal virtues, leading to 'its own dialectic of action and reflection, which is self-corrective and expansive'.[531] This constant dialectic of judgment and anticipation of the results of action is the hallmark of prudence, and this in turn can be seen as a tool which promotes virtuous behaviour. This connectivity of the virtues provides us with 'a program for action for all those who want to grow in personal goodness'.[532] It is the lack of connectivity of the virtues in Bovary which leads to disaster for the patient, and indeed the falling away from goodness in Bovary's character. If Bovary had been more self-reflective one might have hoped

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531 Porter, 165.
532 Porter, 165.

that his virtues, though perhaps never strong, might have held sufficiently to prevent Hippolyte falling through the gaping hole in their fabric. We can here picture the virtues coming together to form a safety net which supports the patient when difficulties arise.

I do not wish to drive a wedge between duty and the virtues, rather the failure of virtue in Bovary coincides with a failure of duty, for it was not his duty to perform an operation on the ostler; indeed we can better say that it was his duty *not* to perform any such operation in view of his lack of expertise. Doctors have a duty to know the limits of their expertise. He should have acted in the interests of the patient and should not have used the patient to redeem himself in the eyes of his wife. The failure of duty and virtue here overlap to a great extent, yet I think it is fair to claim that duty is qualitatively different from supererogation. Duty can be done in a mundane way so long as it is done conscientiously and competently. Supererogation, by contrast, in going beyond familiar paths, tends towards the unusual, if not the spectacular and dangerous, and it is here that virtue is most needed because failures of virtue, and the emergence of vice, show themselves in such a naked manner. As an aggravating factor it often follows that doctors then try to assuage their failure by turning their backs on their patients, as Bovary does his best to avoid the ostler whenever he hears him walking on his artificial leg.[533] That unwillingness to come forward to admit the harm doctors have done is a further aggravation; it shows a denial of 'self-corrective reflection' that doctors need to practice and display if they are to learn from mistakes. That is a blunt failure of prudence.

A template for the application of the virtues in medical encounters can be taken from the work of J. L. A. Garcia.[534] His recommendations concern how to adopt the right approach to friendship, and indeed all role-relationships. He also focuses on one-to-one relationships, and although the doctor-patient relationship is not listed, 'each such role is an analogue of friendship' and 'they are the personal roles, tying a person to a person, involving her in the latter's life, even if only as a distant well-wisher'. On that

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[533] 'The ostler gradually resumed his duties. He was once more to be seen getting about the village; and if ever Charles heard him stumping along in front of him, he hastily turned a corner'. Gustave Flaubert, *Madame Bovary* (London: Penguin, 1988), 201.

[534] J.L.A. Garcia, 'Human Lives' in *Intentions in Medical Ethics,* ed. by D.S. Oderberg and J.A. Laing (London: Palgrave, 1997).

basis it seems fair to include the doctor-patient relationship within that fold. Garcia is interested in the moral relationship 'that is *role-centre, virtues-based, patient -focused,* and is also *input-driven* in its account of the permissibility of actions'.[535] That such an approach is multifaceted is in keeping with the complexity of medical relationships. Garcia contrasts his approach with the 'point of view of the universe' advocated by Sidgwick in the nineteenth century,[536] for supererogation should be confined to the patient before one, and not be thought of in terms of benefit to some group of patients elsewhere. By *role-centred* Garcia refers to the role the agent plays in the life of the subject, so a doctor would concern himself with all the moral features appropriate to that role. By *virtues-based* Garcia refers to the primacy of the virtues rather than that of rights or duties. By *patient-focused* the concern would primarily be for the patient not for the doctor. By *input-driven* we refer to the motivations that drive the agent forward: in friendship this would be love for one's friend. These roles are 'internal, psychological conditions'. He adds that, 'They are orientations of the heart'; the rightness of an action depends on that internal orientation, and so perhaps less on the results obtained (so doing good by neglect could not be right).[537]

To describe Bovary's failure as one of duty would be to under-describe it, for he allowed himself to be swayed against the professional judgement he should have had. We can better interpret it as an over-reaching failure, with one failure compounding another, each perhaps understandable in itself but cascading to a catastrophe. We could say that strength in one virtue cannot compensate for failure in another. It seems to be self-deception, or at least the failure of the recognition of our motives, which leads to the cascade of disaster. A hallmark of this failure is the dogmatic belief that our projects, once undertaken, are best completed.[538] Again, the sign of maturity is a continual reassessment of any course of action, for Bovary might have believed that he was offering a brave and bold service, but he would have been better seeing himself as simply not skilful or experienced enough to venture on such an operation. His lack of autonomous agency led to this disaster.

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535 Garcia, 87.

536 And one wonders if the doctors consulted by Virginia Woolf thought in such impersonal ways. Did they have in mind the universe of *people like her* or the singularity of the *woman* before them.

537 Garcia, 86-88.

538 Jean de la Fontaine's fable in Book 5, Fable 12. *Les Medecins*, points the moral: *Tant-Pis* and *Tant-Mieux* prefer to let the patient die rather than give up their rival opinions.

Madame Bovary can be viewed in the light of Garcia's approach. The operation was not a duty to be performed, was ostensibly offered for the benefit of the patient, and indeed Bovary pays for all the costs of the equipment, so generosity seems to be in the air. Yet from the point of view of the virtues the episode fails at every turn. Applying the four-fold framework of Garcia we can make the following analysis: firstly, it is not role-centred because Bovary is not keeping the patient at the centre of his attention; secondly, the virtues are neglected (not only has he never done this operation before but he has been manipulated by Homais who wishes to bring repute to the town and prestige for himself); thirdly, this was not patient-centred since Hippolyte has a limp but can work well, indeed before the operation he could stand better on his bad leg, so this was clearly not patient-centred;[539] fourthly, Bovary's motivation is to restore his standing with his wife, and he is using the patient for that end.

7.4 Kurt Schwitters and Dr Johnston

Another different example shows firstly, how hard it can be to distinguish between duty and supererogation, and secondly, how the virtues help us to disentangle personal gain from disinterested service. During the Second World War the German artist Kurt Schwitters was living in Ambleside after being released from detention.[540] He and his partner could not afford to keep the room heated even when she had influenza. After asking the GP, Dr Johnston, to visit on his rounds, Schwitters arrived back home and got into bed to keep his partner warm. The doctor arrived, examined the patient, then he too got into bed, all three keeping warm in the unheated room while Schwitters and Dr Johnston played chess with the patient supporting the board between them. Such behaviour is eccentric, and nowadays would be an unthinkable action to take, but in the bitter cold could this not be seen as a welcome contribution to the welfare of the patient, if valid permission could have been obtained? It seems the antithesis of condescension, for Dr Johnston was neither standing aloof nor on his guard, indeed he was simply getting alongside the patient in a supportive way. He was willing to discard his dignity to support his patient, for what could be more

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539 'For a person lamed in one foot supports himself on the healthy one alone'. ST 2-2, Q180, Art 7, Ad 4.

540 Barbara Crossley, *The Triumph of Kurt Schwitters* (Ambleside: The Armitt Trust, 2005).

fundamental than the prevention of hypothermia for a sick patient? Such actions point to the fact that boundaries are indeterminate and much has to be left to the judgement of the doctor. On the other hand, we might now think of his action as outrageous, especially in light of recently reported inappropriate behaviours by doctors which can provoke complaints. We can also think of this action as neither dutiful nor supererogatory, simply a casual, virtuous action which took place during the visit, and to think otherwise would be to over-describe it.

The point of this story is to emphasise that supererogation can be recognised by other commentators after the event, but for the individual doctor and patient there is a wide range of interpretations which can take place.

7.5 Distinguishing Doctors' Duties

Failures of supererogation throw light on the nature of duty by making us question how we define its boundaries. Dr Johnston's eccentric behaviour reaches to the heart of the matter. The question with any odd behaviour might be put like this: the behaviour is unusual but is it *really* outside the doctor's duties? That of course opens it up further: who judges where a doctor's duties lie, who decides what is unacceptable, what constitutes failure?

Our example can be worked out as follows: Dr Johnston found the patient suffering from influenza, in an unheated room, and got into bed with the patient and her partner to keep them all warm. Was that really part of his duty? The answer is not straightforward: if the patient was embarrassed by his action (nowadays it might be described as an affront to her dignity) then the action was not part of his duty, for other resources might have been thought of, such as going to find coal, bringing round a hot meal, and so on. If in fact the patient was comforted by the action and found it a measure of the kindness and trouble to which he would go to help her, then it would be seen in a different light. The details of the case are not recorded in the detail we might wish, so in this case there seems to be no simple way in which the doctor's duties can be decided upon. What we would need for that elucidation would be a

concentration on the virtues and vices coming into play, over and above the actions which have taken place.

The theme that emerges, highlighted by failures of supererogation as described in the fictional accounts, and by borderline cases as with Dr Johnston, is that the range of doctors' activities is so wide that the concept of supererogation becomes unstable in practice. We can see that there are minimum standards of decency which all must fulfil, and there are self-sacrificial acts which fall within the category of supererogation, but in the central area of the spectrum there is no clear boundary between the duty and supererogation. In deciding the category into which an act should be placed, we need to know all the facts of the case, not just the actions involved but also the motivation and sentiments felt by the doctor; and that appraisal calls for good judgement. This makes difficulties for a doctor who questions the nature of a particular action, for what might seem to be optional at first sight might, on reflection, be judged to fall within the bounds of duty. Even in the absence of any formal contract, the notion of a felt imperative clearly has a psychological force (the *ought to*) which can only be ignored at cost to one's peace of mind.

This 'difficult question' is analysed at length by Kirk.[541] He reaches the conclusion that what we might call 'above and beyond' duty is in fact perceived by the agent to be just '*an additional duty*', any praise is due to anyone who does his duty with a good motive no matter how large that duty might appear to us. This undercuts the notion of supererogation, for agents come to see the 'over and above', no matter how extraordinary, as simply an aspect of duty. The concept of supererogation can survive, it seems, only if the circumstances are judged by people other than the agents concerned; we are too caught up in our actions to be good judges of them.

An example of this overlapping, with the running together of duty and supererogation, is Dr Richard Harris, an Australian doctor who put his diving experience to good use in helping to rescue a football team of boys trapped underground in a flooded cave in Thailand in 2018. I first discussed him in section 5.10. His actions are a good example of *doing what needs to be done*, and in this way what we *ought* to do

541 Kirk, 522.

overrides what we are *obliged* to do, as first pointed out by Feinberg. This dissolves the felt boundary between duty and supererogation; indeed, reading the accounts of the rescue leaves one realising that Dr Harris would have been incapable of *not* coming forward. We might say that he felt he was under a 'peculiar obligation'.[542] We could also say that obligation or compulsion drives us forward, and the assignment to the category of duty or supererogation takes place afterwards, though it can be a difficult call to make. Dr Rabbeth and Dr Lucas, described in chapter 1, who were contaminated with sputum from patients with diphtheria, are examples of this. They were praised for their heroic action yet criticized for not taking due precautions, indicating how ambivalent our judgements can be. The worrying conclusion for doctors is that often an act can only be judged to be within or beyond duty *ex post facto*, and the thought that we can simply aim at duty and always hit the mark is fallacious. Put another way, the doctor who sets out to act supererogatorily is setting off on the wrong path; it is better to simply follow the path of service wherever it leads, not knowing at the start just how far the journey will take us.

We can see that if the problems and pitfalls of supererogation are to be avoided then we need to be firmly grounded in a prudential acknowledgement of our technical and moral strengths and weaknesses. Dr Harris was a specialist in anaesthetics, not some medical adventurer intent on glory for himself; he was a very experienced diver, unlikely to be fazed by the technical difficulties involved; he showed phronesis by preparing all the equipment he might need beforehand; and he showed fortitude by keeping his own fears under control.

I offer the example of Dr Harris as an antidote to the three personal failings described above: i) his egoism was firmly under control and did not interfere with the judicious appraisal of the dangers involved; ii) he did not lose sight of the patients, rather he kept them continually in the focus of his gaze; iii) there was no trace of self-deception, indeed his judgement of his own diving skills and his practice in anaesthetics dovetailed together to make the success of the rescue as assured as it might be, notwithstanding the dangers.

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[542] Jane Austen uses this term to describe the felt quality of thankfulness of Marianne to Colonel Brandon after he rushes to bring her mother to her during her serious illness. *Sense and Sensibility,* p. 332.

7.6 An Unstable Concept

I have outlined some problems with supererogation, both theoretically and in application. We can see the concept sliding about under our gaze, clear and definite in cases of self-sacrifice, but in other cases sliding into categories of courtesy, volunteering, and those personal obligations ('ought-to') which seem to an outsider to be more deeply felt than the circumstances warrant. We are here dealing with the world of perceived moral obligations rather than the world of professional duty, more psychologically called for than logically demanded. We are now more at home in a text such as William Hazlitt's essay, *On the Spirit of Obligations.*[543] He offers no formal account of obligations, for his essay describes the texture of *psychological* imperatives; he gives the example of how charitable impulses can coexist with an irritable desire for distinction and praise, showing the strongly mixed nature of our motivations.

7.7 The Daily Round and Going Beyond the Call of Duty

The price of remaining sealed off in the world of dutiful dominion might result in a gnawing sense of frustration, certainly for those who feel they could do more. At other times we might feel a sour mood of dutiful work when our enthusiasm is sharply curtailed. I also pay respect to doctors who believe they work far too hard. I am suggesting that we should not feel ourselves to be the victims of other people's needs but rather in dialectic with them, trying to find an intensity in ourselves which is the antidote to 'burn-out' and other stress related discontents.

This intensity amounts to 'a faculty of sustained attention' to patients, a phrase derived from the work of the poet-critic Geoffrey Hill and echoed in Iris Murdoch's 'attention'; indeed Murdoch claimed 'we need a new vocabulary of attention'.[544] Owen Boynton

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543 William Hazlitt, *Selected Essays of William Hazlitt* ed. by Geoffrey Keynes (London: Nonesuch Press, 1946), 226-240. There is a memorable description of a choleric surgeon who 'has a tendency to probe other wounds besides those of the body'. p.234.

544 From 'Against Dryness' (1961) and discussed in Broackes (ed.) (2012), 34-35.

describes how this faculty accounts for the success of *Middlemarch*.[545] I suggest this is a link between the novelist's and the doctor's way of working. George Eliot brought such attention to her writing that her powers of seeing were heightened, just as a doctor might perceive with intensity that something more than usual is called for, and then respond in a supererogatory way. The attraction of this calling to sustained attention is the possibility that intensity can be heightened without exhaustion following on, something of importance in the third model, *Supererogation as Secular Sanctity*, and shown by Dr Guttman at Stoke Mandeville Hospital.[546]

Boynton demonstrates that Eliot did not simply write with an intense focus but gave as much attention to her minor characters. From the medical point of view the parallel with Eliot would be for doctors to pay attention to all patients irrespective of the importance of the illness for the doctor. In this tension between the seemingly ordinary and the important a balance needs to be found, partly to avoid the exhaustion which too intense a manner can engender and partly to prevent doctors going off in search of the supererogatory at the expense of the ordinary. Thus the reading of novels has the potential to lead to better medicine, for the art of medicine perhaps consists in just such an approach, paying close attention to all who come along, yet finding reserves of energy to make that leap into extraordinary responses. Reading literature has been promoted as a valuable activity for doctors by researchers in departments of the medical humanities. Here I am suggesting that novels do not just give us insight into peoples' fears but illustrate how we can vary our responsiveness to patients in a dynamic way, coping with minor illnesses and not being overwhelmed by them. High quality attention *by itself*, without reaching for the prescription pad, might be as healing as any proposed treatment.[547]

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545 Owen Boynton, 'Middlemarch, Pastoral, and the Waste of Attention' in *Literary Imagination,* 16 (2014), 275-288.

546 'This mountain is such, that ever at the beginning below 'tis toilsome, and the more a man ascends the less it wearies'. Shepherd, *The Living Mountain*, 7, and described by her as 'Dante's law of ascent on the Mount of Purgation'.

547 'Those who are unhappy have no need of anything in this world but people capable of giving them attention. The capacity to give one's attention to a sufferer is a very rare and difficult thing; it is almost a miracle; it *is* a miracle. Nearly all those who think they have this capacity do not possess it'. Simone Weil 'Reflections on the Right Use of School Studies with a View to the Love of God', *Waiting for God* (New York: G.P. Putnams and Sons, 1951), 64. Footnote 7 in Owen Boynton op cit.

7.8 Avoiding Problems and Pitfalls

In this section I hope to show how to avoid the pitfalls described earlier. Drs Bovary and Lydgate lacked the foundations of the telos of medicine and a grounding in the virtues. They failed in their attempts because they put their own ambitions and concerns above patients' interests, harming them and ruining themselves. Doctors might find the burden of patients' illnesses overpowering;[548] this leads to the temptation to deceive themselves by attending to patients in what seems to be a generous way, yet serves to reinforce the doctors' self-opinion. This is the failure of medicine and a human failing too. We might call it a disorder of sensibility. Although I have praised sensibility as a way out of egoism, and although doctors practising supererogatorily have good intentions, yet it needs to be handled wisely. In his Introduction to *Sense and Sensibility,* Tony Tanner refers to Michel Foucault's *Madness and Civilisation.* Sensibility needs to be justly cultivated, for as Foucault writes,

> It is not only knowledge that detaches man from feeling; it is sensibility itself: a sensibility that is no longer controlled by the movements of nature, but by all the habit, all the demands of social life.[549]

If we substitute 'medical life' for 'social life' in this passage, we can begin to understand how medical practice can lead us astray from the suffering under our nose. The way out of this conundrum is to look elsewhere for security, and we do this by giving up the sense of security in our material possessions or in professional reputation, for they can soon be lost. Doctors find comfort and security in working dynamically, and for Christians this would be in the knowledge and love of Christ, yet while supererogation originates in Christian theology, its practice can be adopted regardless of faith or belief. If approached in the right attitude it is not the case that the more we give to others the less we receive for ourselves.

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548 'People in pain are omnivorous in their appetite for help, and they will use us up it we let them', Hauerwas, 'Salvation and Health', 552.

549 Tony Tanner, 'Introduction', in Jane Austen, *Sense and Sensibility* (London: Harmondsworth, 1973), 14.

For Christians, Yeager writes, 'Jesus calls us out of the network of our human loves and responsibilities, calls us to love the absolute God absolutely; however, to do this is to be returned, changed, to the very network of loves and responsibilities that we had thought had been rendered of no account'.[550] In other words we work best for our patients by looking to the love of God, unsettling ourselves first of all, travelling towards that love in the form of religious worship, and then returning to work revivified, looking at last in the right direction. This dialectic, learning to love our patients by first loving God, is at the necessary foundation. That sense of immediacy, of seeing things rightly is also at the heart of the remark by Urmson, introduced in Chapter 1, about how 'on the whole the best philosophy is little affected by theory; the philosopher sees what needs doing and does it'.[551] That 'seeing what needs to be done and doing it' is at the heart of supererogation, and it is the secular equivalent of the Christian approach mentioned above. It is found in Dr Bernard Rieux, in *La Peste,* the novel by Albert Camus, a man without religion and who is practically minded without any grandiosity.[552] Just as we can see that children brought up by loving parents in a stable and supportive home mostly grow up to be well balanced adults with a fine sense of right and wrong, so we might say that doctors whose apprenticeship is secure know the boundaries of duty, at least the boundary separating us from what is wrong. The theme of this thesis however is that the upper extent of our duties is not so easily defined. When have we done enough?

7.9 The gift of attention

I have suggested that the essence of supererogation is the gift of oneself. It might be less grandiose and more straightforward to talk of the gifts of attention, concentration, focus and energy; these amount to the faculty of 'sustained attention'. A dutiful doctor might claim that she aims to practise in that way, sometimes with more energy, sometimes with less, but she wonders what such giving might mean in detail. How to describe this to a sceptical medical student would be difficult, but if we return to Aquinas at this point then we find guidance. We cannot do it unaided: we need to

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550 Yeager, 472.

551 J. Ree and J. O. Urmson, 'J.O. Urmson', in *Concise Encyclopaedia of Western Philosophy and Philosophers* (London: Routledge, 2005), 380

552 Albert, Camus, *La Peste* (Paris: Gallimard, c2008)

seek to become imbued with the seven gifts of the Holy Spirit: wisdom, understanding, counsel, fortitude, knowledge, piety, and fear of the Lord. Four of these direct the intellect; the remaining three direct the will towards God (ST 1-11, Q. 67, Art 6). The gifts are interconnected with the virtues. Perhaps most important of all is for students to cultivate the avoidance of self-deception; keeping the gifts in the forefront of their mind might be a safeguard against this. In this respect Hauerwas is invaluable, being mindful of such dangers.[553] He is strongly in favour of avoiding grandiosity and prefers to think in terms of the hard practical work of 'spelling out' our engagement with the world. We need to know what we are doing and what we are about, speaking clearly, not seeing vaguely. This is a disciplined activity, and for this we need to recognize 'the dominant story, the master image' of our character.[554] We can add to this important insight the recognition that our character partly depends on the stories we are told in childhood and then on the books we encounter as we grow up. This is a further reminder of the fundamental importance of literature in shaping our responses in later life.[555]

A straightforward way for young doctors to think of gifts would be to see the patient's attendance as a gift to the doctor. This was first pointed out to me at medical school by a senior physician. His courteous manner towards patients set the right tone, for he regarded himself as receiving a gift from the patient, having the opportunity to then put his knowledge and professional skills to good use. It seemed to be an old-fashioned way of seeing things, something easy to lose sight of because of the busyness of the hospital wards. The doctor's response then becomes a gift to the patient in return, separate from any payment or contractual arrangement which might be in place.

A way of enlightening what we mean by 'gift of oneself' is to look at the work of John Barclay who has studied gift-giving in the Greco-Roman world of St Paul.[556] He

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553 Hauerwas, 'Self-Deception and Autobiography: Reflection on Speer's *Inside the Third Reich* (1974) in *The Hauerwas Reader*, 200-220.

554 *The Hauerwas Reader,* 649. This includes biblical parables, encountered in a simple form in childhood.

555 Jane Austen shows the bad effects of self-deception in all six of her novels, but especially in *Emma.*

556 John M. G. Barclay, *Paul and the Gift* (Grand Rapids: Eerdmans, 2015).

describes how this multifaceted concept of the gift can be spelled out into the following six aspects or 'perfections':

1. Superabundance - it is extravagant and lavish;
2. Singularity - the loving gesture comes unmixed with other postures;
3. Priority - the gift comes first, unsolicited;
4. Incongruity - given without regard to the worth of the recipient;
5. Efficacy - powerful, accomplishing its purpose;
6. Non-circularity - it is unconditional.

Barclay is interested in how gifts can be perfected, incorporating all six aspects above. This is clearly a multi-faceted approach, highlighting the difference between ancient and modern ideas. For the ancients gifts were part of a complex nexus of reciprocal relations. Barclay's scholarship, based on extensive study of the ancients, and especially of St Paul, shows that the Christian perfection of gift-giving was different from that of the ancients: Christians share the ancient notion of reciprocity but deny that God's grace is bestowed only on the worthy. What is modern is the Western idea of a 'pure gift', made without expectation of reward, and Barclay mentions unpaid blood donations as an example. [557]

A striking phrase in Barclay's study of Romans, referring to the gift of letting others go first in claiming honour, is 'they *strive to be first in being last*',[558] and we saw that in Captain Chavasse. The usual order of precedence was reversed when he waited for other injured soldiers to be attended to first, showing this love of his neighbours in abundance. In another memorable phrase Barclay writes, 'Paul imagines a community so interdependent that all are figures, individually, as *organs of one another* [. . .]; everyone is essential to everyone else.'[559] This suggests that, though separate, we are all members of one body, contiguous and dependent on one another. If *'strive to be first in being last'* gets to the heart of the second species, *Supererogation as Sacrifice,* then Romans 15.1 could be an emblem for the third species, *Supererogation as Secular Sanctity:*

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557 Barclay, 59-63.
558 Barcaly, 510.
559 Barclay, 510-511.

> We then that are strong ought to bear the infirmities of the weak,
> and not to please ourselves.

A junior doctor reflecting on the gift of attending to patients might come to see how limited our normal work has become and how circumscribed are our interactions with patients. The gift of our time and attention is limited for fear of professional 'burnout'. We are mostly only able to offer, borrowing an analogy from Aquinas, 'the imperfection of candlelight' when we might hope, with the aid of the gifts, to offer 'the perfection of sunlight' (ST 1-11, Q. 67, Art 5, Reply 2). Of the examples described above I believe that Dr Harris, in rescuing the boys from the cave, showed all these perfections: he was not expecting any reward for his gift, and there was no 'preening' of himself or seeing himself as a hero. He showed the modest attitude we might expect from a practically-minded, down-to-earth doctor. His gift was non-circular in that saving the boys was its own reward.

This schema of Barclay is useful in allowing us to judge doctors whose work seems to be supererogatory. Bovary, for example, despite his borrowed enthusiasm to do the operation, fails on all six criteria, perhaps with some amelioration of criterion 4. He also fails in the criteria of Garcia described above from the point of view of the virtues. We want acts of supererogation to be both well intentioned and well accomplished, but also to be done virtuously, i.e., with good motivation; these elements can, it seems, be fused together if we combine the criteria of Barclay with those of Garcia. And yet is that all? Can supererogation be simply captured and demonstrated as a gift given virtuously? That may be so, and yet we wonder if virtue is in itself a motivating force. Is there something antecedent to that? I suggest that the missing ingredient from these accounts, pointing us away from any calculative sense of give and take, is the grace of God which is antecedent to the gift itself. In the next chapter I look at this quality and see it as the initiating force of supererogation.

7.10 Conclusion

In this chapter I have described some of the difficulties which lie in wait when supererogation is pursued without adequate forethought. There is no escaping the need for good judgement and discernment, and I believe that examination of literary sources demonstrates the complexities involved. I have suggested how failures of supererogation might be avoided; this includes a development of our sensibility as reflected in the sustained attention which novelists bring to their work. George Eliot's literary technique in *Middlemarch* provides us with a means of advancing our consultations in practice. The richness of her technique suggests to me the intricate depths which doctors could find in patients' accounts of their illness and of themselves. I further suggest that the exploration of those depths will reveal the full humanity of patients and cause a decrease in doctors' egoism. It is only when egoism declines that doctors are able to step forward in a supererogatory way.

In earlier chapters I outlined three models of supererogation, and now I have looked at how the virtues anchor our activities for the benefit of others. In the concluding chapter I intend to show how supererogation can be better put into practice in medicine and what safeguards need to be in place for a good outcome. I hope to show that although exhaustion and professional 'burnout' are reasonable fears of doctors who are thinking of acting in a supererogatory way, in fact, and counter-intuitively, acting supererogatorily might well have the contrary effect.

8. Chapter Eight: Towards a New Intensity

8.1 Introduction

In this final chapter I begin by returning to the coroner's court described in chapter 1 and the forensic examination stemming from the misadventures of Drs Rabbeth and Lucas; their actions can now be reconsidered in the light of subsequent chapters. I then examine the work of Dr W. H. Rivers who pioneered treatment for shell-shocked soldiers, and imagine how a consultation with Septimus from *Mrs Dalloway* might have progressed.

In answer to the question: 'What is the nature of doctors' responsibilities towards their patients?' I indicate how this question can be answered in the light of supererogation. I promote the combination of thoughtful attention, imagination and a striving for excellence as the correct reply to the question.

Running through this thesis are the following threads: Bernard Williams' suspicion of the 'morality system'; Charles Taylor's view that this system privileges the right over the good; Alasdair MacIntyre's emphasis on the telos of human activity and the felt quality of moral life; Levinas's belief in the open-ended nature of our responsibility; Iris Murdoch's condemnation of 'the fat relentless ego'. All these threads are woven into this thesis which is also coloured by the hegemony of duty, brought about by the professionalization of medicine and the shift away from a straightforward view of the patient in favour of the 'medical gaze'.

I am offering a new understanding of duty and supererogation, showing how difficult it is to divide them and how interwoven they are in medical life.

8.2 The Coroner's Court

We are again concerned with the two children with diphtheria who underwent tracheotomy in order to breathe, however Drs Rabbeth and Lucas were contaminated

with infected material from their patients and both died. Let us imagine a fourth scenario, now fully fictional, in which the child dies of a blocked airway but the doctor survives. We return to the coroner's court; let us call this doctor, Dr Stocks, to prevent confusion with the historical doctors we have been considering.

C (Coroner) I understand, Dr Stocks, that in the absence of a mechanical sucker the child did in fact die of asphyxiation brought on by the diphtheria.
S (Dr Stocks) Yes Sir, I could find no way of clearing the airway.

Interruption from the floor of the court by the dead child's father:

F (Father) If that had been me doing that I'd have tried to suck it out myself! Why didn't you do that doctor? You should have done more!

C I deplore the interruption but I can understand the depth of grief which has found its expression in that outburst. Could you comment on that, Dr Stocks?

S I have never heard of such a thing being done, and I'm sure it never entered my head to apply my mouth to the wound. I'm not sure it would have helped anyway, the tissues were so swollen.

C Well, let's get to the bottom of this for the sake of the family's peace of mind. Would it have been possible for you to do that? I don't suppose such a thing is part of your training, and there must be obvious distaste for such a thing. Might it have helped? I am not suggesting that such an unheard of thing could have been part of your duties to the child, I am merely following the line of enquiry.

S I suppose it's possible, though it never came to mind. Perhaps I could have done so.

C Would the thought of washing your mouth with antiseptic solution afterwards have been of any use if such a thing had come to mind? I think we're talking about attempting a desperate remedy for a child who was gravely ill.

S *(Looking distressed)* Well, I have children of my own; perhaps the thought of them stopped me from putting myself at risk. I don't remember it being on my mind at the time, but I can see that if the child had been my own it might have entered my thoughts to have a go at sucking on the tissues. It didn't seem part of what a doctor should do, or be expected to do, but I don't know what to say any more. I might have been able to suck out the mucus, but the trachea was very swollen even so.

I have tried to show in this exchange both the imprecise nature of our duties and a conflict between the doctor's and the father's ideas of what should have been attempted. Directly sucking on the trachea of a child might be outside the range of duties (indeed such a thing is unlikely to have been considered or written down), but the wistful note of, 'If the child had been my own' seems to strike home to Dr Stocks in a way he might not have thought of before. The facts of the case, the proper business of the court, cannot be separated from an evaluation of the doctors' intentions which have led to the investigation itself. Following their lead, we would not want to say that the virtues or vices of protagonists can be separated from their actions; they are not like clothes which we put on and take off, rather they permeate us through and through. This is what is going on when Dr Stocks suddenly realises that he might have failed the child by not doing what the father would have attempted. The idea strikes home when he realises he would have done so for his own child. He has suddenly realised that what was right for the child in the professional sense might not have been the best for the child. The 'morality system' had obscured the good to be done.

If it could be agreed that a doctor's duties do not include sucking out the wound when a mechanical sucker is not to hand, then Dr Stocks, in his capacity as a doctor, was not to blame. What this reveals is that a doctor's duties could never be so comprehensively described; in addition professional duties might be in conflict with moral obligations especially when lives are at stake. I suggest the dialogue above shows Dr Stocks firstly speaking as a doctor and then being drawn into speaking as a parent who could imagine his own child lying before him. That sudden realization is painful to recognise, and he is heard oscillating across the boundary with no comfortable landing in view. Heyd's view, that our duties as doctors can be separated from our duties in person-to-person mode, is hard to sustain. If the father believed he

had entrusted Dr Stocks with his child, might he not also have believed that the doctor would have treated the child as his own, and committed himself to saving the child's life, not just acting as a doctor performing a procedure? If the doctor had seen the child in this manner, would not sucking out the airway, naturally disgusting in prospect, have become in fact a *delight*, both in loving the child and in doing whatever was necessary to save a life? Doctors assume that their own safety comes first, but I am here wanting to point to the primacy of the other. It is love which allows us to turn the tables in this way. We might say that love is both a duty and a delight, even when the actions required are not at all pleasurable. The ordinary example of lancing an abscess in general practice is a good illustration of this.[560]

8.3 Taking Delight in Patients

Let us return to the suffering of Septimus, the patient in *Mrs Dalloway* described in Chapter 4. Neither doctor took any delight in seeing or treating him. There was a failure of communication, with Septimus being unable 'to communicate his experiences to others and thereby give those experiences meaning and purpose',[561] and it is clear that the doctors made little attempt to understand him. His doctors not only failed to acknowledge that gap but they pushed him back into the chaos from which he had emerged at the end of the war.[562] A more generous-hearted practitioner might have been able to impart some sense of chaos being overcome, of his experiences being reconfigured anew. The telos of medicine points us in that direction; it is not simply about curing disease but restoring health, and that is more encompassing than the absence of disease. The doctors in fact try to reintegrate him into the old order of things, they do not validate his suffering. In consequence his identity breaks down completely. His suicide can thus be seen as a refusal to be hammered back into the old ways.

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560 Incising a perianal abscess brings relief to the patient. The smell from the sudden gush of pus might be foul, but it is a delight nevertheless.

561 Karen DeMeester, 'Trauma, Post-Traumatic Stress Disorder, and Obstacles to Postwar Recovery in *Mrs Dalloway*', in *Virginia Woolf and Trauma Embodied Texts,* ed. by Suzette Henke and David Eberly (New York: Pace University Press, 2007), 77-94.

562 We sense that Virginia Woolf's device of chopping and changing characters and times and places reflects the lack of healing taking place.

This alternative view, the view that the repulsion Septimus evoked in his doctors might have been turned into delight if they had perceived a loving way to help him, was given by Mrs Dalloway herself. What seems at first reading to be a disdain of the topic of suicide, for fear it might spoil the tone of her party, is suddenly altered by a Gestalt-like new way of seeing:

> Or there were the poets and thinkers. Suppose he had had that passion, and had gone to Sir William Bradshaw, a great doctor, yet to her obscurely evil, without sex or lust, extremely polite to women, but capable of some indescribable outrage - forcing your soul, that was it- if this young man had gone to him, and Sir William had impressed him, like that, with his power, might he not then have said (indeed she felt it now), Life is made intolerable; they make life intolerable, men like that?[563]

How would the novel read if the doctors had been able to give of themselves to Septimus? If doctors are essentially needed to care for the sick then they need to give something of themselves; conscientiousness is not enough. At the least doctors should not seek to have power over their patients, rather they should seek to capture something of their experience. This takes place as an imaginative leap into the shoes of the other, or indeed inside the skin of the other.[564] What would that mean? Let us look at a doctor who did achieve this.

8.4 Dr William H R Rivers (1862-1922)

Let us devise a thought-experiment between fiction and reality. Imagine Septimus being attended not by the doctors in the novel but by Dr William H. R. Rivers in the flesh. He is remembered for pioneering treatment of shell-shocked soldiers of the First World War, especially at Craiglockhart hospital in Scotland, where Siegfried Sassoon was one of his patients.[565] He observed the patients with detailed attention,

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563 Woolf, *Mrs Dalloway,* 203. This very strong reaction against Sir William Bradshaw suggests he is suffering from the theological disorder of *libido dominandi.*

564 'First of all', he said, 'if you can learn a simple trick, Scout, you'll get along a lot better with all kinds of folks. You never really understand a person until you consider things from his point of view -'
'Sir?'
' - until you climb into his skin and walk around in it.'
Lee Harper, *To Kill a Mockingbird* (Oxford: Heinemann New Windmills, 1966), 35.

565 Rivers has been portrayed in the part-fictional, part-factual account by Pat Barker, *The Regeneration Trilogy* (London: Penguin, 2014)

with an open-minded acceptance of both the symptoms and the patients' accounts; there was no rush to conclusions. Existing pathological models were found to be inadequate and were replaced by new formulations of how the mind coped with terrifying experiences. Dr Rivers helped to shape patients' experiences anew, thereby making something which could be studied and treated in a fresh and non-judgemental way. This was creative in diagnosis and treatment, and I foresee that if Virginia Woolf's own mental illness had been treated by such a doctor, then her depiction of the doctors in her novel might have been drawn differently; she might then have been able to spare the shell-shocked Septimus from the terrifying thoughts which engulfed him.[566]

How good was Dr Rivers? Let us recall Heyd's restriction of supererogation to the good works that are done for the sake of others once doctors are outside their professional roles. Viewed in this light, Dr Rivers satisfied the instrumental and technical requirements, helping patients to recover (though getting them back on their feet and thus being fit to return to the trenches of Flanders disquieted him severely).[567] There is no doubt that he attained the third variety of goodness too: he made new connections; he framed a new way of thinking about mental illness; most touchingly, he transformed understanding of the pathogenesis of shell-shock, viewing putative cowardice as something to be expected of honourable soldiers placed in extreme danger. He saw his patients with personal interest as well as a professional view.

In this light we could paraphrase a comment of Virginia Woolf's on the nature of greatness: 'We have to remember that it is one of the qualities of greatness that it brings heaven and earth and human nature into conformity with its own vision',[568] into a comment applicable to Dr Rivers' excellence: 'We have to remember that it is one of the qualities of medical greatness that it brings health and human suffering into conformity with its own vision'. It is this visionary quality which marks greatness in

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566 Describing him as a shell-shocked survivor who is suffering from post-traumatic stress disorder, DeMeester claims that ' . . .I argue that Septimus's suicide is a direct result of his inability to communicate his experiences to others and thereby give those experiences meaning and purpose'. DeMeester, 77.

567 A view also expressed by Wilfred Owen.

568 Virginia Woolf, 'How should one read a book', in *The Essays of Virginia Woolf, vol I,* ed. by Andrew McNeillie (London: Hogarth Press, 1994), 393.

medicine, and I suggest Dr Rivers did show this quality, including the strength of mind to withstand criticism from colleagues about his new methods.

For all the excellence of Dr Rivers, his achievements thus described are still contained within the boundaries of his professional role and so would not count as supererogation in Heyd's view. Nor perhaps would Dr Rivers have wanted to view his work as above and beyond the call of duty: he was interested in his patients and he was professionally called upon to help them. In this he focussed on the good he could bring about rather than the satisfaction of his contractual duty. It might be agreed that a doctor's duties expand and contract according to circumstances, and that the extraordinary demands of war call for such an expansion. The conclusion is that excellent work might yet not count as supererogation. I propose that the finest doctors stand astride the boundary between duty and supererogation, or, better put, take no notice of such a boundary; they do what needs to be done, neither sacrificing themselves impetuously nor dragging patients recklessly off track. They are simply mindful of the suffering before them and strive continually to relieve it.

In the next section I study what life was like for Dr Rivers and his colleague, Dr Henry Head, both of whom could be said to place a sense of professional duty behind the need to press on with both research and a new approach in their practice.

8.5 Straddling the Boundary

The case of Dr Rivers is complicated by the actions of one of his colleagues, Dr Henry Head (1861-1940),[569] a distinguished doctor with a special interest in neurology. He was intensely hard working and observant, indeed a larger-than-life character. His mapping of the distribution of the dermatomes (areas of skin connected to single spinal nerves) permitted much greater understanding of the dorsal nerve roots of the spine. In fact this work has not been superseded. Before the First World War he became dissatisfied with using patients as test subjects in experiments on the recovery of nerve injuries, so he volunteered to have an operation whereby nerves in his arm were surgically divided. This was followed by five years of observation of

[569] en.wikipedia.org>wiki>Henry-Head [accessed 17 October 2022]

how the nerves regenerated, with his friend and colleague Dr Rivers acting as examiner.

At first sight we might think of this as a simple case of courageously giving of oneself to the cause of medical science. To volunteer in this way, with no certainty of recovery, is beyond the call of duty and so can be seen as a good example of supererogation, at least in the *Beyond Duty* model. To suspect that this was not entirely praiseworthy might seem unworthy, yet our residual fears are that the doctor was seeing himself as a means to an end. We hear so much of 'the medical gaze'; a further worry is when doctors see their own bodies as 'the experimental body', evoking the medical automata of the eighteenth century.[570] A doctor might undergo such an operation in order to promote her reputation as a doctor at the forefront of research.

While motives might be muddy, intention does need to be other-regarding, and it is hard to think Dr Head would have volunteered for such an operation without the intention of helping others. Good intentions do not always have favourable results however, and it is interesting that he was consulted by Virginia Woolf and it did not go well; possibly her illness might have made her unreceptive to his advice. Some doctors might be able to display all the varieties of goodness most of the time, while others might be able to work with technical and instrumental goodness for the most part, with only occasional displays of creative goodness. Yet high reputation can only be built on consistent habits shown to a wide range of patients over many years, and inconsistency is worrying because of its random nature, along with the suspicion that it might arise from prejudice to those patients who leave discontented.

Can we say that Dr Head showed supererogation in his researches and gave of himself to his patients? [571] These things are not quite synonymous, for giving immense energy to one's work seems not to coincide with giving of oneself. Here is an example of this subtle difference: Dr Head was fastidious on his ward rounds, making sure, by varying the pressure from the cotton wool he was applying to the skin, that he

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[570] Martyn Evans describes how the 'medical body' is an object of enquiry, 'a kind of lieutenant for that everyday body'. We could say that Dr Head looked on his own body as 'a source of data'. Martyn Evans, 'The "Medical Body" as Philosophy's Arena', *Theoretical Medicine,* 22 (2001), 17-32.

[571] His work on the 'body schema' is still influential today.

obtained the response he desired from the patient in order to provide clear demonstrations of nerve function. He would become anxious to do this well.[572] This sense of frustration with patients who do not have the ability or presence of mind to give the responses desired by the consultant is commonly observed by medical students who are both impressed by the skill and slyly amused by the vanity of doctors on such grand teaching rounds. I have observed in myself the power of the 'fat, relentless ego' when teaching medical students. That intrusion of the ego masks the honest account, commonly allowed, that teaching others in fact shows us how little we know, not how much.

I suggest that giving of oneself has less to do with displays of skill and much more to do with obtaining the best from patients by incorporating them as part of the whole process; they should not be treated as objects of display who have to be coaxed into giving the desired responses. It would have proved more impressive to show the medical students how to speak to the patient with infinite care and patience, being less concerned with performance and more concerned with evoking the cooperation of patients, however imperfect their responses might be. That is what is of universal human importance. In Chapter 4 I explored how the condescension of the professional stance separates us from patients: doctors rise higher by standing on their shoulders and playing to the gallery. By contrast, indeed what is a delight to witness, is when doctors never separate themselves from the welfare of their patients, even when the importance of evoking subtle signs is needed for the sake of the medical students looking on.

Dr Rivers showed thoughtful attention towards patients and this necessary ingredient of supererogation in medical practice can now be looked at more closely.

8.6 Beyond Empathy

That doctors need to be empathic towards their patients is a commonplace remark, yet this is hard to achieve. It might be compared with the slow progress of a pilgrimage,

572 Russell Brain, 'Henry Head: The Man and his Ideas', *Brain*, 84 (1961), 561-566.

bringing about an altered mental state as we get closer to our destination. Let us look at some of the steps on the way:

1. If sympathy can be equated with feeling sorry for the patient's suffering, then empathy goes beyond this into an attempt, or an imaginative leap, into vicarious experience of what the patient is feeling. It is stepping into their shoes. Sir William Bradshaw took no imaginative notice of what Septimus might have been feeling; he jumped to conclusions based on his own narrow professional experience.

2. Empathy might be an intense state, yet it seems to have a passive quality. Going beyond empathy, I suggest, requires the doctor to act as a leader in navigating the patient away from the suffering state towards recovery. It is in search of 'meaning and purpose' as described by Karen DeMeester.

3. The active quality of leadership is shown by work and application. For example, Dr Rivers was easily fatigued after an attack of typhoid while at school, but he strove to overcome this as is apparent from his publications and from first-hand accounts.

4. Empathic doctors can lead the way in changing public perception. Patients' experiences, especially of something as widespread and controversial as shell-shock after the First World War, needed to be incorporated into the public's understanding that a new disease has been discovered. Time was required for the wounded veterans of the war to be accepted back into civilian society, and this was difficult for many. A more recent parallel would be the incorporation of HIV/AIDS patients into society.

What does it mean to go 'beyond empathy'? I suggest it is not simply feeling the patient's pain alongside the patient, having some grasp of what they are going through independent of our sympathy for them. I think it is a much more active engagement. Doctors who achieve this level of support suffer along with their patients; yet because they are in good health themselves they are able to transform that suffering in a positive way. The literary scholar, Barbara Hardy, in critical studies of Jane Austen, George Eliot and Thomas Hardy, wrote of Hardy's characters that they 'haven't the

faintest idea of what is happening to them',[573] something also true of many ill patients in my experience. His characters, along with Dorothea Brooke in *Middlemarch*, are said to show 'lives made creative and painful by radical imagination', and this suggests both the pain and joy of living with imagination in the service of others. It is far removed from the doctors described in Chapter 2, where Mr Friday is served by two disengaged doctors, the one uninterested in medicine, the other forgetting the nature of suffering. They lacked creative imagination and so, though able to relieve his pain, were unable to relieve his deeper suffering.

I suggest that the modern notion of empathy actually amounts to thoughtful attention suffused with imagination. If founded on virtue that is itself action-guiding. I perceived this fusion of qualities when I attended a lecture as a medical student from Dame Cicely Saunders, a few years after her foundation in 1967 of St Christopher's Hospice in London. She had been struck by how cancer patients who were found to be incurable were left to fend for themselves. Hospital care came to an abrupt end and the patient was sent back to the GP with a letter saying there was nothing further to be done. This was a blindness, both to the suffering of the patient and to what could be done in the development of terminal care. Her vision transformed the treatment of such patients. Before this they had been discharged by hospital doctors, the GP's care at home then meant a prescription for 'Brompton cocktail'.[574] Afterwards, thanks to her vision, they were befriended and cared for at all levels, and medicines were administered separately and with discrimination. Their suffering was the focus of her thoughtful attention, and her imaginative approach showed that even patients with so-called 'total pain', on high doses of morphine, could have their pain relieved, not by increasing the doses ever higher, but by sympathetic and endless attention. In fact some patients can gradually come off morphine if these other routes to analgesia are pursued. This good came about because she put her imagination into practice; it did not involve a difficult technical problem, but was about a change of attitude, seeing things afresh. Dame Cicely Saunders navigated the route to a new destination.

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[573] Barbara Hardy, 'Preface' in Thomas Hardy, *The Trumpet-Major* (London: Macmillan, 1974), 12.

[574] A potent elixir of morphine, cocaine, chloroform and alcohol; though in widespread use it provided uncertain analgesia and caused addiction and undue sedation.
'The medicines of the physician are often the greatest torment of the incurable patient'. Smith, *TMS*, 175.

8.7 Goodness and Supererogation

How do empathy (or imaginative, thoughtful attention), goodness and supererogation interrelate? Dr Rivers and Dr Head were distinguished doctors who showed all three varieties of goodness, the technical, the instrumental, the artistic greatness. Dr Rivers, in his visionary and courageous standing forth against the criticism of colleagues, showed the giving of oneself which marks out his excellence. I suggest that acts of supererogation both partake of, and point the way to, those higher varieties of goodness to which we aspire, especially the giving of oneself. From the point of view of pilgrimage, supererogatory acts stand as milestones on the way. If we liken the destination to a recovery of health, then an extension of this metaphor would be to point out the route-finding quality of supererogation. Just as Virginia Woolf's depiction of Septimus shows him going round in endless circles of suffering, so Dr Rivers, in the consultation I have in mind, might have been able to point the way; he would have straightened out the route.[575] Dr Head suggested Virginia Woolf should be admitted to a nursing home, a standard course of action favoured by Sir William Bradshaw in the novel, but that would have been going round in circles too, taking her endlessly back to the beginning of her suffering. We might now say that such suffering has to be 'reframed' if we are to progress beyond it.

Giving of oneself is marked by selflessness and generosity. It is reminiscent of the Good Samaritan whose actions were in the same category as Christ. Supererogatory acts leave us weaker and more vulnerable to others, and the commitment has an open-ended quality. This again illustrates the imprudent aspect of supererogation which is at odds with justice viewed as fairness; indeed it seems to transcend justice and prudence. This is at the heart of those criticisms of the Postman's Park doctors discussed in Chapter 1, whose 'heroic self-sacrifice' was both praised and criticised at the time. The tension here is important.

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[575] 'Forgetting that he was a doctor and that I was an "interesting case", I answered his quiet impartial questions as clearly as I could, with a comfortable feeling that he understood me better than I understood myself. Rivers never seemed elderly; though there were twenty years between us, he talked as if I were his mental equal, which was very far from being the case. I was really very ignorant, picking up my ideas as I went along, but Rivers always led me quietly past my blunders'. John Stuart Roberts, *Siegfried Sassoon* (London: Metro Publishing, 2014), 122.

This deeper level of interpersonal behaviour is made up of two intertwining strands: firstly the application of scientific knowledge; secondly the intangible giving of oneself which is concerned with both cure and healing. By cure I am thinking of the absence of evidence of disease; by healing I am thinking of the patient's incorporation of the experience of illness into a new whole, something at the heart of Dr Rivers' work, and something which Virginia Woolf was never to achieve, even in the intermissions of her mental illness.

I am therefore trying to synthesize a new understanding of supererogation, seeing it strongly intertwined with excellence and empathy, for 'a three-fold cord is not quickly broken' (Ecclesiastes 4, 12). Good doctors who strive to be excellent in their work cannot help but incline toward supererogation once they have developed their practice of perception and empathy.[576] They continually 'lean into' their patients and then try to pull them out of danger or at least relieve their suffering. Thus excellence continually encroaches upon the supererogatory, incorporating it into new schemes of good medical practice, with ever new perceptions of suffering and disease. This state of mind was perhaps at the heart of the comments made by Urmson in his later retraction of the new category of 'Desirable but not Obligatory' and described in Chapter 1: 'on the whole the best philosophy is little affected by theory; the philosopher sees what needs doing and does it'.[577] This suggests an immediacy, far removed from the view *sub specie aeternitatis*, something not disdainful of moral theories but reaching deeper to the heart of what informs our desire to stand alongside the suffering of others.[578]

An important by-product of this focus on supererogation is that it rebounds back onto our understanding of our basic moral obligations, as with the doctor on the desert island, denuded of all medical equipment. Paraphrasing Iris Murdoch, doctors might say, 'We are men and women, and we are moral agents before we are doctors, and the

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576 'And a three-fold cord is not quickly broken' . Ecclesiastes, 4. 12.

577 J. O. Urmson, *Philosophical Analysis: its Development Between the two World Wars* (Oxford: Clarendon Press, 1956), 200.

578 Heyd points out that contract theory is the most satisfactory ethical theory for the explanation of supererogation. Heyd, 95.

place of medicine in human life must be discussed in *words'*.[579] This fundamental primacy of our moral obligations, coming before professional duties, can be found in Aquinas (ST, 1-11, Q 38, Art 3), and his comforting words are applicable to all patients, and I especially have in mind the injured Mr Friday from chapter 2:

> When one is in pain, it is natural that the sympathy of a friend should afford consolation: whereof the Philosopher indicates a twofold reason [. . .]. The first is because, since sorrow has a depressing effect, it is like a weight whereof we strive to unburden ourselves: so that when a man sees others saddened by his own sorrow, it seems as though others were bearing the burden with him, striving, as it were, to lessen its weight; whereof the load of sorrow becomes lighter for him: something like what occurs in the carrying of bodily burdens. - The second and better reason is because when a man's friends condole with him, he sees that he is loved by them, and this affords him pleasure [. . .] it follows that sorrow is mitigated by a sympathizing friend.

However we are medically qualified men and women too, and our duty is inextricably mixed with the foundation of our moral obligation: we cannot act just as moral agents or just as doctors. We comfort patients by attending to them both as the men and women we are, showing them the suffering we feel on their behalf, *and* as doctors, even when denuded of all medical accoutrements on desert islands. When the two aspects of doctors meet in happy conjunction then the benefit to patients can be profound and memorable.[580] Thus care and comfort come first, with diagnosis and treatment supervening upon that. The patient who is cured without such essentials might feel used and hard done by; the dark humour of 'The operation was a success but the patient died' points to this divergence.

With this in mind, can we now indicate what the doctor should have done for the child whose neck he had cut open, but whose trachea could not be intubated because of the swelling of the tissues? Should he or should he not have put his lips to the wound to suck open the airway? We remember that he was both praised and criticised at the

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579 'We are men and we are moral agents before we are scientists, and the place of science in human life must be discussed in *words.* This is why it is and always will be more important to know about Shakespeare than to know about any scientist: and if there is a "Shakespeare of science" his name is Aristotle.' Murdoch, 'The Idea of Perfection', in *The Sovereignty of Good,* 33.

580 'Many of us looking back through life would say that the kindest man we have ever known has been a medical man, or perhaps that surgeon whose fine tact, directed by deeply-informed perception, has come to us in our need with a more sublime beneficence than that of miracle-workers.' Eliot, *Middlemarch,* 628.

time by other doctors, so the answer is not obvious. We now come to a fork in the road. If we think of him acting in a remote way, *sub species aeternitatis*, then we can see him having the knowledge required and yet being paralysed by the lack of a mechanical sucker. We could describe him as an 'impartial spectator' of events, lacking any sense of radical imagination. On the other hand, if we think of him travelling together with his patients, attending on the sick child in the absence of the parent, then the further along they journeyed together the closer would have been the relationship between them: they would have shared bodily discomforts and eaten bread together, at least metaphorically. The longer we journey together the closer we become, and our egoism diminishes into a new form of joint concern for the members of the group. Our ego boundaries become porous in the face of our shared embodiment, connecting us interpersonally at a deep level. This is a sign of loving concern, beyond justice, beyond codes of practice, an adoption of others. If the doctor had taken the stance of adoption of the child before the operation then he *should* have acted as the father might have done and sucked on the wound: he would have been wrong not to have done so (in this respect treating the adopted child like his natural children), simply responding with a loving action. Sucking on the wound would have been a sign of how open-ended are our responsibilities to one anther, as Levinas indicated.

If he had not taken the stance of adoption towards the child it is understandable that he would not have put his mouth to the wound, indeed such an action might simply not have come to mind. It is thus that our actions are governed by our attitudes based on relationship which arises from the *status quo ante* of how we view our attachment to the patients we attend.[581]

Sir William Bradshaw's lack of radical imagination stems from a failure to acknowledge our shared embodiment which prevents his taking up the stance of adoption. In the adoption of children we take on the whole child, in all its bodily, intellectual and emotional aspects, and we should not be fastidious in attending to the child's bodily needs with as much loving concern as we can find. Parents who are not

[581] 'We act rightly "when the time comes" not out of strength of will but out of the quality of our usual attachments and with the kind of energy and discernment which we have available.' Murdoch, *The Sovereignty of Good',* p. 89.

attuned to their own bodily functions find this difficult: they show disdain to their own and their children's needs. Mark Hopwood has studied the importance of embodiment in another twentieth century novel, *Howard's End* by E. M. Forster, in which he traces the significance of the famous epithet, 'Only connect . . . ' to lie in the simple idea of connecting with others, and more importantly, to connect with our deeper, hidden selves.[582] Doctors who do not recognise their own embodiment are likely to be condescending to patients; they do not recognise the painful embodiment of others, adopting a superior tone and failing to connect with their suffering.

Supererogation is easy to discern as a separate entity when we are standing far back from the work place, but at close quarters duty and supererogation intertwine to form a strong bond of attachment between doctor and patient. I compare this medical movement across that boundary with the religious movement from meditation to contemplation which has been described by Sarah Coakley.[583] 'Meditation' might be compared with modern professional development: the continual mulling over the day's activities; the keeping of a 'reflective diary'; the discussion with colleagues, trying to identify one's strengths and weaknesses. 'Contemplation' is more concerned with a detachment from self, indeed a 'self-effacement', and letting oneself be penetrated by pathos, and illuminated by the love of God and concern for others. In a parallel way, supererogation is also about making ourselves more vulnerable to others, especially when they cannot help themselves.

Sir William Bradshaw was busy with the diagnosis and treatment of his patients, yet we would not accuse him of wanting to become more vulnerable to patients or of wanting to 'heal' them. 'Healing' has come to mean a cluster of changes centred on care but not necessarily requiring cure; it is concerned with the emergence of a new sense of self. By contrast, Dr Guttmann could be described as a healer, for he promoted the flourishing of his incurable patients, in some cases taking up sports such as archery, thus gaining some agency over their paralysis.

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582 Mark Hopwood, 'Only Connect: Moral Judgment, Embodiment, and Hypocrisy in *Howard's End*'. *Philosophy and Literature*, 40 (2016), 399-414.

583 Sarah Coakley, *Power and Submission, Spirituality, Philosophy and Gender* (Oxford: Blackwell, 2002). Coakley points out the danger of women being pushed down into submission by men who promote self-effacement for others while neglecting it themselves.

8.8 Duty and Delight in Dorothy Day

The nature of human flourishing has been studied by Stephen J. Pope.[584] Pope first describes prisoners facing life imprisonment, yet finding grace and acceptance within the promptings of a Dominican order. Before prison they had enjoyed some prosperous freedom in living for themselves, yet they came to find *more* flourishing within prison, despite being deprived of the many good things they had previously enjoyed. He then describes Dorothy Day (1897-1980), a journalist who became a Catholic at the cost of her marriage, and was a prominent activist for the Catholic faith in the USA, becoming engaged with movements against war, poverty and injustice, amongst other causes. She lived a life of voluntary poverty, existing on hand-outs of food and clothing, devoting her energies to the welfare of others, an example of flourishing in the midst of poverty. She was a co-founder of the Catholic Worker Movement in 1933, and combined non-violent but energetic activism with daily contemplation. Her life is of interest for this thesis as she combined both courageous and mundane care and concern for others with deep meditation and thoughtfulness. Her diaries reveal a spiritual flourishing in a life of material poverty.[585]

Pope distinguishes between three varieties of human flourishing: the Dialectical view; the Humanistic view; then, synthesizing these two together, the Incarnational View. The Dialectical view centres on the renunciation of flourishing in worldly terms, following self-sacrificial means to attain salvation. The Humanistic view promotes our flourishing by finding joy in living for others, but only as a means to being loved ourselves. The Incarnational view sees Christ as the epitome of human fulfilment, that God is one of us and his grace is in us. Incarnational flourishing does not embrace suffering in a masochistic sense, nor does it see suffering as a means to the pursuit of God's love; we accept the paradox in worldly terms that flourishing means *more* suffering, and that pursuing that suffering enables us to share in God's love,

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584 Stephen J. Pope, *A Step Along the Way: Models of Christian Service* (Maryknoll, NY: Orbis, 2015)

585 Dorothy Day, *Duty of Delight: The Diaries of Dorothy Day*, ed. by Robert Ellsburg (Milwaukee, Wis: Marquette University Press, 2008).

doing so with a good heart and a good grace, being neither resentful nor full of conceit. We share the suffering of others as Christ suffers with them and us.

I am not claiming that there is any easy comparison of my three models of supererogation with Pope's three varieties of human flourishing, though there are features which resonate. For example, Day regretted that the time she spent working meant that she had little time to spare for her daughter, just as Chavasse's heroism meant that his fiancée was left alone at the end of the war. These examples might be thought of as a voluntary kenosis, pouring out our love for others even at cost to ourselves. What does seem clear is that ultimate human flourishing is found in being with and giving up our comfort for the sake of others, and that is at the heart of supererogation.[586] Doctors especially seem to be pointing in that costly direction because of the nature of their work, and this finds expression in many forms.[587] Chavasse seems a good example of how doctors can incarnate both the love of Christ and the suffering of patients and not baulk at the cost; they become the flesh which houses the new spirit of God within.

The essence of supererogation might be compared with the benefits of contemplation, the vision of God, sometimes achieved by prayer. Kirk describes how prayer can lead to moments of ecstatic contemplation:

> At such moments the worshipper is lifted out of himself into a higher and better atmosphere, which leaves traces for good in his soul when it returns to its normal lower level.[588]

If achieved by such self-denying practices then those 'traces for good' must surely have counted as a delight to Dorothy Day.

For Christians there is always more that could be done, and that is in the difference between the dutiful ruler who has kept the commandments 'from my youth up' and the

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586 'My mother used to tell us stories about inventors and doctors who gave their lives for the suffering, and poor boys who struggled to the top of the tree, and saintly men who made examples of themselves'. Robert Graves, *Goodbye to All That* (London: Penguin,1979), 31.

587 'The nature of being a doctor is to go above and beyond to deliver the care our patients require.' Message to the Profession from Dame Clare Marx, President of the GMC, March 2020. during the Covid pandemic.

588 Kirk, 206.

superadded requirements described by Christ when the ruler asks, 'What shall I do to inherit eternal life?' The reply is to 'sell all thou hast, and distribute unto the poor, and thou shalt have treasure in heaven.' There we see the high cost of supererogation if we think of what has to be given up for a distant reward. The sorrow we feel at giving up our possessions is shown by our deafness to the last words of verse 22 when Christ said, 'and come, follow me'.[589]

By contrast, earlier in Luke 7 we find the story of the centurion whose servant 'was sick, and ready to die' and although the centurion was judged to be a worthy man for Christ to consider ('for he loveth our nation, and he hath built us a synagogue') nevertheless as Christ drew near, the centurion sent word 'saying unto him, Lord, trouble not thyself; for I am not worthy that thou shouldest enter my roof'. The centurion was a man of authority and Christ 'marvelled at him' saying, 'I say unto you, I have not found so great faith, no, not in Israel'. It is that modesty in the centurion which illustrates the grace which I am describing. It is an attractive quality, equating with the modesty of doctors who are competent, perhaps distinguished, yet always aware of the limitation of their powers in dealing with the complexities and calling of the patient they are attending.

8.9 Moral Modesty

This sense of modesty is desirable in doctors, signalling only a qualified belief that the work has been done, the cure achieved and care accomplished. The tension between the dutiful and those inclined towards supererogation can be likened to the tension between valid and invalid theories of the Christian life. This has been analysed by Kirk in *The Vision of God*; it amounts to a perpetual dichotomy between those who live a Christian life within the world and those who desire to escape the world's trappings in order to come closer to God.[590] The sense that duties can be circumscribed, limited by custom and practice while being part of a respectable and charitable life, is the prevalent Christian view. Can we extrapolate from this and say

[589] Kirk points out the 'peculiar turn' taken by Augustine's spirituality which emphasised the blessing of what was on offer, not on what was being given up. Kirk, 255.

[590] One might compare York Minster with Fountains Abbey, the former in the world, perpetually repaired and renewed, the latter remote from towns and people. The ruins of Fountains Abbey tell their own story.

that the life of the simply dutiful doctor, with time found for family life and recreation, is inferior to the life of the doctor who devotes all his life to work? The invalid theory seems to suggest that this is so, but Kirk describes many examples of how such simple approaches were frowned upon.

A more mature way of thinking, according to the valid theory, is to think of Christian life as one long process of ever deepening conviction, with no fundamental distinction between monastic and secular lives. One might move from a life of worldly success towards a life of contemplation, and then perhaps back again, responding to how one perceives the best way of serving others for the sake of God. Kirk gives an example of such a formulation in Gregory the Great's writings.[591] For proponents of the valid theory the monastic and secular forms of Christianity were not different in kind but only in degree.

In this light I see no sharp dividing line between duty and supererogation in medical practice. This is a morally modest position to adopt; it leaves doctors free to pursue what is important for the patient, not just what is required by the morality system. Scholars might emphasise the formal, analytical separation between them, but once we are involved, once a doctor is in relationship with a patient and really seeing what is going on, then withdrawal becomes increasingly difficult. Not only is the separation between duty and supererogation hard to discern when close up, but the boundary between my models of *Supererogation as Sacrifice* and *Supererogation as Secular Sanctity* becomes less marked: the two models overlap to some extent.

In the next section I give an illustration of how these two approaches can live together under the same roof, both being seen as serving God.

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[591] 'We cannot stay long in contemplation . . . we can only glance at eternity through a mirror, by stealth, and in passing; [. . .] we have to return to the active life, and occupy ourselves with good works. But good works help us again to rise to contemplation, and to receive nourishment of love from the vision of Truth [. . .] Then, once more moving back to the life of service, we feed on the memory of the sweetness of God, strengthened by good deeds without, and by holy desires within.' Kirk, 252.

8.10 Martha and Mary

I began this thesis with a claim that *The Good Samaritan*, Hogarth's mural in St Bartholomew's Hospital, points to the need for doctors to act generously towards patients. Can the relationship between duty and supererogation also be represented in painting? I believe that it can, and we find this in Vermeer's *Christ in the House of Martha and Mary,* in the Scottish National Gallery. The familiar account in St Luke is short enough, only five verses at the end of Chapter 10. Biblical exegesis usually equates the sisters as showing the difference between worldly and monastic approaches, with Martha laying the table and bringing the bread, while Mary is the contemplative one at Christ's feet (ST 11, Q179, A2). This encounter between Christ and the sisters has been subject to much commentary.

Let us look at the painting in the traditional, patriarchal manner which Vermeer has chosen: Martha brings food to the table, and so let us think of Martha representing duty, for she provides food for their guest, while Mary represents supererogation, for she has transcended duty, taking advantage of the opportunity to hear Christ speaking directly to her. Martha is resentful at being 'cumbered about much serving' and says to Christ, 'Lord, dost thou not care that my sister hath left me to serve alone? bid her therefore that she help me' (Luke 10, 38-42), yet Christ gently rebukes Martha, pointing to something more essential than the provision of bread on the table.[592] Mary looks fixedly on Christ, while Martha looks at him too, but with averted gaze, for she has been chastised and feels it. Martha might be thinking that our spiritual hunger can hardly be satisfied when we are distracted by an empty stomach, while Christ is not disdainful of Martha, rather he is asking her to look at life anew. Mary is listening to Christ, meeting his need to be heard while benefiting from his teaching. Perhaps she has washed his feet and is lingering there.

But let us look at the painting with a different gaze, for Christ is depicted with his right hand open towards Mary while he looks at Martha, holding them like the hinge of a diptych; indeed each wing would be diminished without the other. Christ's look

592 'To give our Lord a perfect hospitality, Mary and Martha must combine.' St Teresa of Avila.

at Martha is an invitation to see the world from another point of view, to sense the importance of his teaching. The painting illustrates Christ's invitation to leave behind our usual way of seeing: we are not *either* active in the world *or* contemplative thinkers. Various commentators have addressed this passage, including St John Chrysostom who emphasised the importance of being attuned to what was important at any given moment. Aquinas also pointed out that activity and contemplation should go hand-in-hand, with no rigid separation: we pass on to others the benefits of our contemplation (ST, 2.2, q,188, a 6). Recent feminist scholars have added greatly to this. Elisabeth Schüssler Fiorenza examines the text closely, trying to find the origins of the 'androcentric dualism' of the sisters, and utilising a 'hermeneutics of suspicion' to tease out the traditional assumptions we have about a woman's place in the home and what constitutes 'women's work'.[593] In this regard, Schussler Fiorenza shows the complexity of our relationships, and that there was no easy dualism between the roles of women and men. In this I see a parallel with my desire not to cleave duty from supererogation but to see an overlapping interaction between them. Sook Ja Chung also takes a feminist perspective in which she challenges the view that women's work is of inferior value. Viewing Christ as one of the oppressed, she claims that both Martha and Mary served him as best they could, with Martha doing 'table mission' because she was unable, just at that time, to listen to him.[594] In like manner, doctors do their duty but are not always able to do supererogatory work, though this does not prevent their moving from one point of view to another.

There is another way of seeing this painting. The art historian, Lawrence Gowing[595] shows how Vermeer painted what his eyes could see, not what his mind told him should be there.[596] It was this so-called 'passivity' which gave Vermeer the discipline to see and record what was before him, not to impose his knowledge on his sitters. His pictures have a modesty about them, not just in subject matter, but in his *handling* of paint. One wishes that Sir William Bradshaw had handled his patient with such

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593 Elisabeth Schüssler Fiorenza, *But She Said: Feminist Practice of Biblical Integration* (Boston, Mass: Beacon Press, 1992), 55-75, p 70.

594 Sook Ja Chung, 'Bible Study: Women's Ways of Doing Mission in the Story of Mary and Martha', *International Review of Mission,* 93 (368), (2004) 9-16,

595 Lawrence Gowing, *Vermeer* (London: Faber and Faber, 1970).

596 For example, a hand holding a dish from underneath is little more than a blob of paint. Vermeer avoids the temptation to depict the anatomy of the hand which would not have been visible in the dark shade.

modesty, listening with whole-hearted attention, not intruding upon him but taking in all Septimus was saying while listening out for what he was not saying. This habit takes good grace and self-discipline to put into practice. Unfortunately he boldly claimed, with a knowing self-righteousness, that he could see what he could not in fact have seen or heard. He had been led astray by the seduction of the medical gaze, just as some of Vermeer's contemporaries painted incidental details which were beyond the artist's gaze. What I am claiming here is that superb technical skills, as demonstrated by Vermeer and by many doctors, should be combined with modesty in their wise application.[597]

Doctors should respond to the invitation held out to them by patients; to recognise the limits of their practice, to see beyond the obvious, and to accept with humility that the medical gaze is a blinkered view, taking in only a portion of what is there to be seen. Guidance on the limits of doctors' duties should be followed in order to indicate the perils of falling below a minimum standard, but fresh ways of looking can be found. Learning to see what lies before us is perhaps the hardest thing we can be asked to do; we need to be taught. A good bedside manner is not enough; we should feel the pathos of life and respond to it as fully as we can. Doctors should remain alert to the diagnostic signs they are able to discern and evoke, but they have the opportunity to remain alive to the penumbra of distress and suffering; this is commonly swept aside for fear that too much poignancy, once admitted, will obscure their diagnostic probing.

8.11 Conclusion

I began this thesis with a description of the history of supererogation and indicated how it disappeared from view. I began with the *Beyond Duty* model, founded on Aquinas and the distinction between precepts and counsels. In chapter 2 a distinction was made between our professional duties and moral obligations, and I claimed that their growing separation came about because of the professionalization of medicine. Chapter 4 focussed on the felt quality of this divergence as illustrated in Virginia Woolf's novel, *Mrs Dalloway*. Throughout the thesis I have indicated how novels and

[597] Vermeer used a camera obscura in his studio.

the humanities provide us with insight into the nature of our obligations. Doctors can easily become deflected from them because of the exigent demands of the biomedical model viewed through the blinkers of the 'medical gaze'.

I then described a second model, *Supererogation as Sacrifice,* as demonstrated by Captain Chavasse, and followed this with a third model, *Supererogation as Secular Sanctity,* which I claimed is the best of the three models for application to modern medical practice. I used two classic novels, *Middlemarch* and *Madame Bovary* to illustrate the pitfalls and dangers of supererogation when applied with too little care, and finally I promoted the introduction of supererogation. If supererogation cannot be put into practice then it should at least be considered: *What more can I do for this patient?* is the pertinent approach rather than the question, *Have I fulfilled my duty?*

My purpose has been to strengthen the cohesion between our moral obligations and our professional duties, for I believe that any divergence between them is bad for medical practice. Supererogation will always remain optional, but I believe that coming to see our duties through the lens of supererogation has the potential to improve medical practice for the benefit of patients and doctors. We enter onto an upward spiral. The application of supererogation does require wisdom and good judgement if it is not to misfire and cause harm to patients and damage to doctors' reputations.

8.12 Postscript

In 1968, ten years after his 'discovery' of the new category of 'Desirable but not Obligatory', Urmson published a book, *The Emotive Theory of Ethics.*[598] While he found little to attract him to this theory, he concluded that its errors were 'the imperfections of the early formulations of insights which have become of great importance to modern philosophy'.[599] In this light, I hope that this textured interpretation of supererogation in medicine, with insights from my own practice, might point the way to further formulations of the concept and the application of supererogation in medical practice. By looking so closely at supererogation I believe

[598] J.O.Urmson, *The Emotive Theory of Ethics* (London: Hutchinson University Library,1968).
[599] Urmson, (1968), 148.

that I have shown how doctors can come to see themselves and their patients in an important new light.

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