The Concept of Service in Medicine
Stanley Joel Reiser, MD, MPA, PhD
The George Washington University, School of Medicine and Health Sciences, Washington, DC, USA

Abstract
This essay examines the origins, influence, and importance of service in medicine. It defines the concept, discusses its evolution from Hippocratic to modern writings, and describes the significance of service for contemporary physicians and patients.

Key Words
Service, history, ethics

The ideal of service is widely proclaimed in the halls of medicine as central to its being. But just what is meant by the term service? How has service been given in health care? Where did the commitment to it go and why? How can its elevation improve health care? This essay examines these questions.

The concept of service in medicine historically embraces a commitment to benefit for their own sake and good the subjects of care, the knowledge of practice, and the civic and medical institutions that safeguard health.

Fulfilling this commitment at times has required practitioners to suspend their ordinary expectation of material return for work performed. This viewpoint is advanced in the Hippocratic essay Precepts, which counsels physicians: “Consider carefully your patient’s superabundance or means. Sometimes give your services for nothing.” Why should physicians and other health professionals be obligated to help, without a necessary connection between giving care and getting compensation? This question goes to the heart of the meaning of doctors to people. Their knowledge of how to relieve and heal pained and troubled persons, and to maximize the possibilities of health, is so important to human comfort and survival that its use transcends the ordinary exchanges of commerce. It requires instead the stimulus of ethics, and the conviction that it is wrong not to confer the power of this knowledge on those who could benefit from it.

Studying the art of healing puts the learner in a moral realm, filled with obligations concerning the use of acquired skills. Its powerful and direct connections with transcendent human experiences, such as suffering and the threat of death, create an imperative to help others with their skills, which disciplines without such associations do not share. To serve...
individuals with their learned knowledge is a basic and nontransferable duty of physicians. An important dimension of this duty is stated in the first precept of the 1957 ethical code of the American Medical Association: “The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.” This precept names service to others as the most important obligation of doctors. It specifies further that this service affirm the ideal that all people are worthy and should be treated with the same dedication, thus embracing the principles of equality and justice. This obligation requires practitioners to suspend judgment about the lives of the people seeking their care. Who they are, where they are from, what they have done, and so forth should not determine the care they receive. Equality requires that care should be given according to the medical needs of people, and without moral judgments passed on them. We are relentlessly judged in life—by family, peers, employers, teachers, and most people and institutions we encounter. Civilized life needs oases in which all people can present themselves to others as they really are, in order to be helped. This is a major role of health care. However, for people to make such disclosures about self requires a deep trust that the person to whom this openness is given will not stand in judgment about what is heard, and not seek to reprove or penalize them for their transgressions and failings, only aid them. The provision of equal and nonjudgmental care is a pivotal objective for practitioners striving to serve humanity.

A further dimension of service to humanity is the obligation of practitioners to help the community by assisting the civic institutions that maintain its health, and by educating its people and taking part themselves in preventing disease. This view is found in the 1847 first code of ethics of the American Medical Association: “As good citizens, it is the duty of physicians to be ever vigilant to the welfare of the community and to bear their part in sustaining its institutions and burdens.... It is their province to enlighten the public...in regard to measures for epidemic and contagious diseases; and when pestilence prevails, it is their duty to face the danger...even at the jeopardy of their own lives.”

Running historically parallel to the obligation to serve individuals and health-preserving institutions has been a duty to serve the body of knowledge that bounds health care, called in Hippocratic writings the art. As the Hippocratic treatise *Epidemics* declares: “The physician is the servant of the art.” Such service embodied a commitment to secure the basic soundness of the art, and to prevent inappropriate extensions of its reach. This perspective is explored in the Hippocratic treatise *The Art*: “If a man demands from an art a power over what does not belong to the art, or from nature a power over what does not belong to nature, his ignorance is more allied to madness than to lack of knowledge. For in cases where we may have the mastery through means afforded by a natural constitution or by an art, there we may be craftsmen, but nowhere else. Whenever therefore a man suffers from an ill that is too strong for the means at the disposal of medicine, he surely must not even expect that it can be overcome by medicine.”

In the Hippocratic view, the need to respect and protect the art was central to having patients believe its claims. Disregarding the limits of remedies harmed treated patients, and discouraged future patients who might be helped by the remedies from accepting them. To serve the art required practitioners to study, understand, and enlarge its capabilities, and to resist using it wrongly, despite the entreaties of patients and families or the practitioner’s own search for personal gain or protection. Practitioners today face a similar dilemma when they must decide, under family and legal pressures, whether to engage in end-of-life heroics that they know cannot save the patient. To strengthen the art and defend the knowledge base of health care from harm and diminishment constitutes an important aspect of service.

In sum, the concept of service has four essential elements: to secure the health of people and the institutions that sustain it; to provide health care equally and nonjudgmentally and to treat people as ends, never as means; to assure the integrity of medical knowledge; and to do this all with benevolent intent. In some instances, these ethical
commitments can be achieved through the daily efforts of compensated work. Other circumstances, involving significant needs that would otherwise go unmet, require an expenditure of uncompensated, volunteered work. Uncompensated acts of service for unmet needs are the most tangible representations and significant demonstrations of health care’s embrace of the service ethic, for here self-interest is maximally reduced. Providing uncompensated service, when needed, places the action in the realm of altruism, and demonstrates the unwavering commitment of practitioners to bestow the benefits of health care on others.

Significantly, the transformative influence of service can affect donors as much as recipients. This perspective emerges from remarks about a relationship with a homeless person made by a health care professional as the 1990s were ending: “Knowing Dorothy has not only motivated me to help her access another program—dental care, nutrition, and drug treatment. Rather, I was invited to cross the line and see her as another person with dignity; we became connected and committed as human beings.” This experience taught him that providing health care to the poor was not just a matter of public responsibility, of developing the right policies; it also was a matter of personal recognition, of “seeing the poor in the first place.”

The donor found value in the small steps an individual can take to help others, even in the face of large, unmet community health needs.

Reflecting on the satisfactions, hazards, and meaning of service in America, the physician and writer Robert Coles also discovered powerful donor effects as he recorded stories that students and older people told “of their tutoring, befriending, feeding, their efforts to heal others.” He learned that the call of service for some was a summons not just to help others but also a reminder to self: to face the darkness of human mortality through an effort “to shine for one another before, soon enough, we join it.”

As health care, like other American enterprises, increasingly absorbs the commercial spirit of the society, what is to be gained by seeking to elevate the service ethic? The gain is to exhibit the selfless, altruistic dimension of the healing arts, which is a basic element of the moral authority of practitioners, and a crucial factor in creating the trust that permits them to help people. Further, the gain is to assure that the growing power of health care innovations is used appropriately, and to facilitate the allocation of their benefits humanly and fairly.

Preserving and giving strength to the service ethic in contemporary times requires its cultivation, study, and transmission by significant health care institutions that can be its champions, notably the nation’s academic health centers and medical schools. Not only do they exert authority over educational curricula and scientific research programs, but they also either own or have strong relations with the hospitals and clinics, and themselves often have faculty-run practice plans. They also have a place and stake in the health and welfare of the communities in which they reside.

There always has been a conflict of interest built into the exchanges of doctors and patients under the fee-for-service method, whose origin goes back to ancient Greek times, and before. With this payment mode, doctors could earn more by doing more. Ethical standards were created in medicine by the Greeks to balance this conflict in favor of patients, and thus to shield those made vulnerable by illness from having their interests overridden by the self-interest of their medical caretakers. The Hippocratic Oath proclaimed in its first ethical principle a commitment by doctors to seek only the benefit of patients and never knowingly to harm them. The oath further declared that students beginning the study of medicine who would not swear to abide by this and the other ethical precepts in the oath would not be taught the knowledge of medicine. From such traditions evolved the ethic of service, with its commitment to seek the good of the patient as an end in itself.

Until the 1960s, managing this conflict of interest was essentially the prerogative and responsibility of the practitioner, whose clinical and ethical judgment determined the care given. In the mid-1960s, a modern health care ethics movement began that focused on patients’ rights and the need to involve them in deciding the alternatives of care. This enlarged the decision-making process and moderated the conflict of interest problem for practitioners, now joined by informed patients.
as equal partners in making health care choices. 9

But the arrival of managed care in the 1990s brought with it a capitated system, whose annually assessed payments for defined groups of benefits reversed the conflict of interest incentive that existed under fee-for-service practice: the corporation could earn more by doing less. To achieve the control it needed to assure profitability and compliance with contractual agreements made with payers, the corporation wrested away from practitioners, patients, and consumers considerable authority over health care choices, and challenged their autonomy in making decisions about health and illness. In response, practitioners, patients, and consumers sought to foster the legislative and legal regulations necessary to reduce the economically derived hold on care assumed by commercially focused health care corporations, and health insurers as well, culminating in the 2010 passage of the Patient Protection and Affordable Care Act.

But even as these governmental actions seek to achieve greater equity in the distribution of health care resources, something more is needed. This more is elevating the concept and ethic of service in health care, as a countervailing force to its commercial dimensions. Service, integrated into the mission and work of medicine, signifies the physician’s transcendent role as a healer of people.

References