

Supererogation: the dwelling of heroes and saints

SADJ August 2019, Vol. 74 No. 7 p401 - p403

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CASE

After managing several patients on the Transnet Phelophepa Health Care program, the students retired to the cabin and reminisced over the occurrences of the day. A particular case stood out for most of them, as they recalled the story of an eighty something year old, old timer, Motsamai Keikemetse.

He was particularly grateful for the treatment he received at the train. Several extractions, new pairs of glasses and comprehensive medical examination were undertaken without any payment. All this care he retorted, could only be described as a miracle. Yet, he spent the night at the train station because he did not have money to travel home that late. Like most villagers, he relied on the kindness of strangers and available public transport to commute to and from the train.

As the dental students interrogated this case, several suggestions came through on how each of the students could have intervened. For some students, all was well and nothing out of the ordinary happened to the old timer. For some, had his situation been known a bit earlier, serious intervention would have been warranted to ease his life woes.

For others, such actions were seen as intrusive on the man and his way of life, and are, in fact, interferences. This case scenario questions the categories of actions likely to be considered and executed by students whether they are justified or not.



Figure 1. The Good Samaritan by Vasily Surikov.

Without placing any moral judgments on their utility and value, one would ask if there is any system to classify and order actions as performed by health professionals. Are some actions morally superior or preferable to others? And if so, how do we know which option to choose under what clinical circumstance?

INTRODUCTION

The media is littered with a litany of accusations of misconduct by health professionals. Hence, the urgent need to interrogate this unfortunate deterioration in relationship between the profession and the public.

The causes of this deepening mistrust emanate in part from professional arrogance, negligence, ignorance, unintended medical errors and unprofessional behaviour, amongst others.

For example, health professionals have been accused of being paternalistic in their dealings with patients; having defrauded patients; having poor bedside or chairside manners; having caused patients physical, psychological and emotional harm. This decline continues unabated, prompted, lest we forget, by Life Esidimeni and similar atrocities.

Unless the profession honestly examines its moral character and conduct and how it treats the public, nothing will change. The *status quo* ought to change, or else health professionals will continue to enjoy and abuse their unwarranted stature and prestige, to the detriment of the unsuspecting public.

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This position of privilege bestowed on health professionals requires from those professionals a greater measure of compassion, reciprocity and responsibility towards the society.

Maybe this expectation of clinicians is unjustifiable and probably unachievable from fallible beings. If so, why then should clinicians enjoy higher social standing and be regarded as having higher moral capacity than ordinary citizens, and why has the society accorded this status to health professionals? Is this position a necessary condition or is there reason to expect conduct that is above reproach from these cadres? And if so, what actions are morally, legally and socially expected, optional or forbidden from clinicians?

Duties performed by practitioners as enshrined in codes of conduct and ethical guidelines are unclear and yet prescriptive. They do not provide clarity on the moral character and value of an act, but rather whether the act is permissible or prohibited. Yet, increasingly, practitioners have gone beyond the call of duty, or are expected to do so by the communities they serve. This has created unrealistic expectations from the profession.

Is it reasonable for health professionals to strive for altruism, sainthood or even heroism in discharging their duties? In other words, is the health profession the kingdom where saints and heroes dare to dwell... or ought to?

Supererogation: normative description

Heroic and saintly acts are supererogatory deeds that go beyond the ordinary and mundane activities. Humanity yearns to celebrate brave men and angels and to vilify as fiends those who fail or elect not to be courageous.

These reactions are testament to the insatiable desire for heroes, saints and martyrs. There seems to be an increasing expectation for saints among the health professionals in particular!

Debates on the conceptual definition of supererogation traverse moral, ethical and religious considerations. Since time immemorial, Christian belief and other religious teachings have demanded acts of faith beyond common courtesy. For example, the faithful have been called to "love thy enemy", and "forgive many times over" and "turn the other cheek". This call to act beyond the common cause provides a foundation for religious belief and sets a goal for achieving piety.

The philosophical interrogation of the morality, duty and virtue of supererogatory acts highlights a dual taxonomy including and extending from deontological to axiological moral perspectives. The former viewpoint emphasises a duty based definition, while the latter highlights value based notions. In other words the nature of philosophical debates on obligation for supererogation range from considering actions that are "good" to do, to those we "ought" to do; or from value or virtue to duty or obligation.

Therefore supererogation lies at the intersection of the axiological and the deontic theories; that is between the

'good' and the 'ought' to activities. Common language expresses supererogation as performing those activities classified as "beyond the call of duty.", or "paying out more than is due", or "doing more than you're expected or obligated to."

Supererogation – duty or virtue?

Can actions be considered supererogatory? And if so what characterises these actions? Is it their intrinsic value or is it the good or deontological thrust or force that confers this character?



Since moral norms provide a yardstick for conduct, it follows, *prima facie*, that all moral actions would fall into one of three categories: those actions that are required, forbidden, or permissible (i.e. either necessary, prohibited or optional). In other words, this triad of actions can be good to do, hence required; or bad to do, hence forbidden; or morally neutral or inconsequential, hence optional. Intuitively this classification represents all possibilities of the actions which may be expected of health professionals. For example, a dentist is **obligated** to treat, **prohibited** from harming and **may** provide services to patients or choose to refer.

Urmson¹ posited another category of actions, that is supererogatory, or morally praiseworthy, but not morally required activities, an example being those acts by saints and heroes. The existence of the fourth category of actions, the supererogatory acts was explicated by Mellema^{2,3} and by Hale⁴ as actions that fulfil the following criteria: (1) acts without moral duty, (2) acts that are morally praiseworthy, and (3) acts which are not morally blameworthy when omitted.² This current classification gives effect to the fourfold description of the required, forbidden, permissible, and supererogatory. The litmus test for a supererogatory action entails excluding whether those acts are the 'one should do', 'ought not to do', 'advisable to do', **but** 'ought not to do but may as well do'.

This Western interpretation of supererogation is diametrically opposed to African ethics. African morality⁵ is weighted more on duty and obligation than on rights as a means to conduce welfare. According to this morality, duty and supererogatory obligations are indistinguishable, because an act that is morally good and commendable in its value and consequences cannot be optional. It is hence commonplace that '...an African will give his best house and evening meal to a guest without the slightest thought that he is doing anything extraordinary'.

CASE DISCUSSION

Interestingly, the responses of the students to the case of Mr Keikemetse represent a diversity of moral viewpoints, which could be attributed largely to the upbringing and culture of the students.

For a majority of African students, it was morally required or obligatory to intervene and assist the old timer. Yet for the white students, whose moral norm emanates largely from libertarian and rights based viewpoints, it was neither obligatory or necessary to assist. These views as held by students do not suggest any superiority in moral positions, but simply the plurality of moral standpoints.

It is critical to recognise that the views of students did not incorporate the expectations of the communities. This means that, in considering the merits of this case, the students were oblivious to the needs and desires of the society they serve. They expressed their opinions on the matter and not necessarily how they would act when faced with this reality. That situation would in all probability impact on their decision and the intention to act or not in a particular manner.

By implication, this would mean that clinicians should always be cognisant of the culture and practices of the people they serve. This would surely be a critical consideration in their decision making. For example, if it is an expectation that elderly persons should be assisted, surely every practitioner as members of the society will be expected to do so despite his or her own moral viewpoints.

It is thus imperative to bring to the centre of debate the application of African moral philosophical viewpoints such as Ubuntu as a guide.⁶ It is our opinion that teaching this moral philosophy will enable practitioners to navigate ethical dilemmas that are bound by context. As the saying goes 'whilst in Rome do as the Romans do.'

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