Between Beneficence and Justice: The Ethics of Stewardship in Medicine

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In an era of rapidly rising health care costs, physicians and policymakers are searching for new and effective ways to contain health care spending without sacrificing the quality of services provided. Many have pointed to the need to eliminate waste and unnecessary procedures in the provision of health care (Kilo and Larson, 2009, 89–91; Sirovich et al., 2008, 849–52). Others have pointed to the need to bring about and support a just health care system on the other. Seen with clear eyes, stewardship in medicine is neither a consequence of beneficent medical care nor a substitute for justice.

I. BETWEEN BENEFICENCE AND JUSTICE: THE ETHICS OF STEWARDSHIP IN MEDICINE

In an era of rapidly rising health care costs, physicians and policymakers are searching for new and effective ways to contain health care spending without sacrificing the quality of services provided. Many have pointed to the need to eliminate waste and unnecessary procedures in the provision of health care (Kilo and Larson, 2009, 89–91; Sirovich et al., 2008, 849–52). Others have...
called for efforts to reduce variation in clinical practice and the consequent need for medical associations to formulate clearer and more uniform standards of care (Fisher, Bynum, and Skinner, 2009, 849–52). These proposals are increasingly articulated in terms of an ethical duty of stewardship (Reuben and Cassel, 2011, 430–31). In general, stewards are persons who are charged with the task of taking good care of that with which they have been entrusted. Physicians, and other health care professionals, it is said, should view themselves as stewards over their society’s stock of health care resources. The following statement on “promoting good stewardship in medicine” from the National Physicians Alliance captures the spirit of the idea.

Americans are concerned about the quality and cost of health care. Unfortunately, some elements of the health care system include expensive practices that do not improve health and in some cases cause harm. Practicing responsible medicine means always doing what is best for the patient while being mindful that resources are finite and that doing more does not always mean better care. (Smith, 2011)

Yet while talk of stewardship in health care is gaining popularity, the content of the idea is often unclear. Different writers invoke it with different purposes in mind. What is more, medical ethicists have not had too much to say about the concept.¹ No doubt this is true in part because the appeal to stewardship in medicine is a relatively recent development. But it may also stem from the suspicion that the language of stewardship does not add anything new to the debate over health care and responsible medical practice. The suspicion is that the concerns expressed by stewardship can and have been expressed in more familiar language by invoking concepts such as beneficence and justice. If this suspicion were right, then appeals to a duty of stewardship would be otiose and they might do more to obscure than to clarify the issues they address. The purpose of this article is to rebut this suspicion by presenting a critical analysis of the notion of stewardship, which shows that it has an important and distinctive place in medical ethics. As I explain, to preserve the integrity and usefulness of the notion of stewardship in medicine, it is vital to distinguish its demands from demands that can be better expressed in other terms. It is also vital not to claim too much for the idea.

II. SITUATING STEWARDSHIP

For many people, the term stewardship has religious connotations.² God entrusted the earth to human beings, and human beings have a consequent duty to take care of what has been entrusted to them. But the idea of stewardship is not essentially religious. Certainly those who recommend stewardship in medicine do not need to be committed to any religious claims. They need only think that there exist resources related to the provision of health care that some people, and in particular those in the health care professions, have a duty to use responsibly.
This thought is an appealing one, but it is not uncontroversial. Not everyone will accept that health care professionals are stewards over their society’s health care resources. Some will object that there is no societal stock of such resources and therefore no need to assign duties of stewardship over it. They will say that, like other goods and services, the supply of health care resources should be determined by the demand for them in a free market. This is one important view on stewardship, a skeptical one. Yet, once societies start recognizing an entitlement to health care, and all modern societies have done so to different extents, the need will emerge to contain the costs of spending on medicine. As many have observed, health care spending consumes more and more public dollars. With limited budgets, wasteful spending on some patients will leave less money left over for others. Stewardship in medicine comes into play when the costs of health care have been socialized, at least to some significant extent. But because this is the reality in modern societies, talk of stewardship over the resources spent on health care in these societies is not out of place. Indeed, even those who would favor a purely privatized system of health care can accept that, if public money is to be spent on health care services, then it ought to be spent responsibly.

Physicians and other health care professionals may be in a good position to exercise the needed responsibility. But if there are duties of stewardship in medicine, they need to be distinguished from other duties that also apply to these professionals. In other words, the duties of stewardship should not reduce to more familiar, and hence better understood, duties. So the first and most important task in getting clear on the idea is to carve out a space for stewardship in medicine. To begin with, consider the claim that physicians should not order unnecessary tests or prescribe treatments and procedures that have no medical benefit. This claim is not controversial. It is a claim, moreover, that is well expressed by appealing to the traditional medical duty of beneficence. As the Hippocratic Oath instructs, physicians should act in the best interests of their patients, and when they subject their patients to unnecessary procedures, they evidently fail to do so.

It is true that when physicians order unnecessary tests and perform unnecessary procedures, they are not simply harming their patients but also wasting resources. Nonbeneficent wasteful medical practice has two bad effects: it harms patients and it depletes health care resources. But it is the first of these effects that is primary, for even if health resources were not limited, but abundant, it would remain the case that physicians should not order unnecessary tests and treatments. Think of a patient who has suffered severe harm as a result of being subjected to an unnecessary procedure by his/her physician. It would be inapt to object to the physician’s conduct by pointing out that s/he has wasted society’s resources. This would be inapt because the wrongfulness of his/her conduct is more perspicuously described in terms of his/her evident failure to act in the best interests of his/her patient.
These remarks suggest one test for an adequate account of stewardship in medicine. The duties of medical beneficence should not covary with the duties of stewardship. There should be some instances of bad stewardship that are not also instances of nonbeneficent medical practice. My discussion so far has focused on the practice of health care professionals. The duty of stewardship is a duty of clinical medical ethics. But the champions of stewardship in medicine often assert that stewardship applies at the societal level as well as at the bedside. “The highest level of stewardship,” some advocates assert, “should be at the national and state policy levels, at which strategy about public funding and public health is developed” (Reuben and Cassel, 2011, 430). Others claim that stewardship in health care engages concerns about the proper distribution of health care resources, and it requires societies to ensure that all their members have access to a decent level of health care (Nichols, 2009, 30–32).

These claims, I believe, should be resisted. While there is little question that modern societies need to develop strategies to guide health care policy and that social decisions need to be made about both the level of funding for health care compared with other social goods and the types of procedures and treatments that should be funded, these matters are better viewed as matters of distributive justice than as matters of stewardship in health care. They are better viewed as matters of distributive justice because they involve conflicting claims on limited resources; and the fair resolution of conflicting claims on limited resources is what distributive justice is all about. If a society spends less on health care and more on education, then that is a social decision about the fair use of public funds. Likewise, if a society rations health care resources so that more urgent needs are satisfied before less urgent ones, then that too is a social decision about the fair or just use of limited resources. Subsuming issues of justice under the idea of stewardship is not helpful because philosophers and medical ethicists have been developing accounts of just health care for some time and little is achieved by recasting this work in terms of a new concept. If the demands of stewardship at the societal level simply reduce to the demands of justice at that level, then once again the idea of stewardship is doing no real work.

It might be objected that stewardship at the societal level can make difficult justice decisions unnecessary. For example, if wasteful and unnecessary medical procedures were eliminated, then, or so it might be said, hard decisions involving conflicting claims could be avoided. Stewardship at the societal level might make the just rationing of health care unnecessary. There is some truth in this thought, but it should not be overstated. Given increasing advances in medical technology, we should expect the cost of health care to continue to rise and more efficient uses of these resources will at most diminish, rather than eliminate, the need to make justice decisions about conflicting claims on health care resources. As I explain below, there is a role for stewardship at the societal level, but it is not the role of achieving...
These remarks suggest a second test for an adequate account of stewardship in medicine. The duties of justice in health care should not be coextensive with the duties of stewardship at the societal level. Taken in tandem, the two tests suggest that stewardship, while relevant to medical beneficence and to just health care, is not reducible to either. The domain of stewardship in medicine is set neither by the demands of beneficent medical care nor by the need to adjudicate conflicting claims over limited health care resources.

III. THE PRIMARY DOMAIN

Have I eliminated the need for the concept of stewardship in medicine? The worry, to recall, is that the language of stewardship expresses demands that can be articulated more perspicuously by appeal to other more familiar moral concepts in medicine, such as beneficence and justice. Responding to this worry led us to distinguish stewardship from beneficence at the bedside and from justice at the societal level. Stewardship in medicine, we might now say, applies in the space between beneficence and justice. But is there any such space? And, if so, how might it be best characterized?

Start with the idea that stewardship in medicine concerns the responsible use of medical resources. As one writer has recently claimed, “Limiting beneficial services is not part of the definition of stewardship; responsible use of resources is” (Fine, 2011, 23). This claim points us in a promising direction, but it needs to be explored and amplified. Irresponsible use of health care resources can be a matter of nonbeneficent medical care. As we have seen, when a doctor orders an ineffective treatment for a patient, the doctor harms the patient. By doing so, s/he uses medical resources irresponsibly. However, and more interestingly, the irresponsible use of health care resources can also occur when no failure of beneficence takes place. To see how, consider a simple example. Two treatments, let us suppose, exist for a given medical condition. Both treatments are effective and neither has been shown to be superior to the other, but one treatment is considerably more expensive. When a physician orders the expensive treatment for his/her patient, s/he does not treat the patient in a way that violates his/her duty of beneficence, but s/he acts irresponsibly, nonetheless. His irresponsibility lies in the wastefulness of his decision, and this wastefulness is a matter of ethical concern when the funds available for health care are limited. An appeal to the duty of stewardship is helpful here, because it highlights an ethical failing on the part of the physician that is not well expressed by the duty of beneficence.

Our simple example is not an unusual occurrence in contemporary medicine. As has been widely reported, physicians often prescribe more expensive
brand name pharmaceuticals instead of less expensive, but equally effective, generic drugs (Studdart et al., 2005, 2609–17). In doing so, they increase societal health care costs, thereby reducing the resources that can be spent on others. The same can be said of medical conditions that admit rival treatments, none of which has been shown to be clearly superior to the others. Patients diagnosed with prostate cancer or atrial fibrillation, to take just two examples, confront a range of treatment strategies for which there is no scientific consensus that one is superior to the others (Consensus Report, 2009). In these areas of medicine, physicians and patients have wide discretion to select the option that they think best.

It will be helpful to have a general name for the areas in medicine where physicians and patients have this type of discretion, that is, where they confront more than one treatment option in which, according to the best evidence available, no one option is superior to the others. Let us call an area of this type a zone of discretion. Within a zone of discretion, selecting any of the available treatment options is fully consistent with the physician’s duty of beneficence toward his/her patient. Within this zone, physicians are free to rely on their hunches and personal styles to select an option.

The duty of stewardship, it now can be said, is a duty that applies primarily to this domain. Considerations of good stewardship direct health care providers to select the most cost-effective response among the eligible options in a zone of discretion. When they do so, they act responsibly because they act in a way that responds to the fact that health care resources are finite and that excessive costs for some leave less for others. They also act beneficently toward their patients, because they do not act in a way that is contrary to the best medical interests of their patients.

This analysis assumes that the medical duty of beneficence is determined by the intersubjective judgment of the medical scientific community. If the available scientific evidence does not favor treatment A over treatment B, then a physician is not required, under the principle of beneficence, to select one option over the other. This remains the case even if the physician personally believes that treatment A is the better option. This may strike some as mistaken. Should not the duty of beneficence be fixed by a doctor’s own best judgment as to what is best for his/her patient? A little reflection suggests that the answer is no. This is apparent when the doctor is mistaken about which treatment option is better. If the available evidence indicates that treatment B is better than treatment A, then the fact that a physician judges that treatment A is better than treatment B does not show that s/he satisfies the principle of beneficence in prescribing treatment A.4

Does the analysis presented here unduly restrict the role of stewardship in medicine? Duties of stewardship only come into play in what I have termed zones of discretion. In the next section, I discuss how the duties of stewardship might be extended beyond their primary domain. For now, I want to emphasize just how prevalent zones of discretion are in contemporary
medicine. According to the highly respected 2009 Institute of Medicine report on comparative effectiveness in health care, there are at least 100 topics that need to be investigated to determine what treatments and strategies are best. In many areas of medicine, the report points out, there is little evidence on the comparative effectiveness of competing strategies. The co-chairman on the panel that produced the report observes that “health care decisions too often are a matter of guesswork, because we lack good evidence to inform them” (Meier, 2009). Without good evidence, physicians rely on their hunches and personal views.

More research on the comparative effectiveness of rival treatment options should be undertaken, and if it were, it would likely reduce the size of the zones of discretion in the areas studied. Zones of discretion are a product of two factors: (1) the fact that some conditions can be treated equally well by different treatment options; and (2) ignorance, given existing evidence, as to which of several treatment options for a given condition is superior. Comparative effectiveness research can reduce zones of discretion by removing ignorance. It is even possible that, at the limit, the growth of medical knowledge could eliminate all discretion from medicine. The duty of stewardship might then cease to have application, but we should not expect the substantial contraction of zones of discretion any time soon. If acted upon now, the duty of stewardship in medicine, even if it were limited to its primary domain, could save billions of dollars in a health care system like the United States.

IV. EXTENDING THE DOMAIN

The duty of stewardship applies primarily to the zones of discretion that physicians and patients confront in contemporary medical practice. I have emphasized that when physicians act on this duty in these zones, they do not violate their duties of beneficence to their patients. The reason for this is that stewardship comes into play when no evidence exists that one treatment option is superior to others. However, a good case can be made that limiting stewardship to the zones of discretion would sell the duty short. On reflection, it appears that the same considerations that support a duty of stewardship in its primary domain speak in favor of extending it a bit more widely.

To see why, consider a different version of our simple example. Two treatments exist for a given medical condition. Both are effective at treating it, but one option is only slightly better than the other. This option, however, also is vastly more expensive than the slightly less effective option. Call cases of this kind high cost/marginal benefit cases. If the physician opts for the less expensive option in this type of case, then s/he will be acting responsibly in the sense that s/he will be conserving limited health care resources. But
now, strictly speaking, s/he will be outside a zone of discretion and s/he will
not be acting in the best medical interests of her/his patient.

In response to high cost/marginal benefit cases, some proponents of stew-
ardship take a hard line and insist that physicians must never prescribe the
less expensive option. The duty of beneficence, they say, takes precedence
over the considerations that motivate stewardship. As the passage quoted
above from the National Physicians Alliance proclaims, “practicing respon-
sible medicine means always doing what is best for the patient . . . .” But while
this response is understandable, it looks to be too uncompromising. Surely,
at some point, the excess cost of a marginally beneficial medical procedure
should make it irresponsible to prescribe it.

In considering this issue, we should take seriously two alternative responses
to high cost/marginal benefit cases. Stewardship, to recall, is premised on
the idea that health care resources need to be used responsibly. Physicians
who act as good stewards use these finite resources responsibly, keeping
one eye on the needs of their patients and another on the needs of countless
other patients. The duty of beneficence in medicine, however, traditionally
has been understood in maximizing terms. The physician should provide
the best possible care for his/her patients. This sets the stage for conflicts
between duties of beneficence and stewardship, because sometimes the
best possible treatment will be unreasonably expensive. But the conflicts
could be avoided altogether if beneficence were understood differently. The
principle of beneficence need not be presented as a maximizing princi-
ple (Beauchamp, 2008). Its content could be informed by other considera-
tions, including stewardship. For example, on a nonmaximizing conception
of medical beneficence, health care providers could be required to provide
the best treatment for their patients from among a set of eligible treatment
options. The determination of the eligible set of treatment options could be
sensitive to a range of considerations, including those that take account of
the societal costs of providing patients with different possible treatments.

This first response broadens the domain in which stewardship applies by
incorporating its demands into the formulation of the principle of medical
beneficence itself. In this way, it gives stewardship a broader role in medi-
cine, while maintaining the thought that the duty of beneficence and the
duty of stewardship, strictly speaking, do not conflict. However, it can be
objected that this response simply covers up the fact that, in some situations,
beneficent care for patients needs to be subordinated to stewardship. After
all, it will remain the case that even if the physician has no beneficence-
based duty to provide his/her patients with the best possible medical treat-
ment, these patients will continue to have an interest in receiving the best
possible medical treatment. Duties of stewardship would continue to conflict
with this interest.

A second response to high cost/marginal benefit cases acknowledges the
potential conflict between beneficence and stewardship but insists that each
imposes demands that are prima facie, not conclusive. It maintains that the
duty of stewardship does not apply merely in zones of discretion but is a
duty that applies throughout medical practice. As such, it must be weighed
against beneficence and other duties; and in some cases, it will take priority
over the demands of beneficence. This response raises its own problems.
Physicians may not be in a good position to balance these types of consid-
erations. It is often pointed out that “resource allocation decisions are policy
decisions that are most appropriately made at the system level, not at the
bedside” (American College of Physicians, 2011; Reuben and Cassel, 2011).
And the duty of stewardship, on this second response, seems to require phy-
sicians to make these resource allocation decisions.

So both of the alternative responses to high cost/marginal benefit cases
raise valid concerns. These concerns will suggest to some that the duty of
stewardship should be confined to the zones of discretion in contemporary
medicine. Extending stewardship beyond its primary domain will be contro-
versial, and it may engender the suspicion that stewardship is a euphemism
for rationing resources at the bedside. That is why I have insisted that the
duty of stewardship should be understood to apply primarily within the
zones of discretion. Nevertheless, as I have said, it is difficult to believe that,
at least in some situations, the excessive cost of treatment options relative
to their marginal benefit should not call them into question on grounds of
responsible resource use.

It is possible that medical associations and other health care professional
organizations will provide the right type of response to high cost/marginal
benefit cases, one that avoids the difficulties we have been considering.
These associations could take stewardship considerations into account when
articulating standards of care in different fields of medical practice. The goal
here would not be to make system-wide determinations of proper resource
allocation to patients, but rather to target wasteful and low-value interven-
tions within each specialty (Brody, 2010, 283–85). A number of organizations
and associations have already started to take the lead in this task (The Good
Stewardship Working Group, 2011, 1385–90). In time, their efforts may prove
to be an effective way of extending the reach of stewardship in medicine
while making it clear that stewardship is not a disguised form of rationing.

Even if the domain of stewardship were extended beyond its primary
application to the zones of discretion, stewardship in medicine would not be
a substitute for health care justice. According to the analysis I am offering,
good stewardship in medicine is compatible with an unjust distribution of
health care resources. Physicians, and professional health care associations,
can make responsible decisions about the use of scarce resources, eliminat-
ing waste and reducing reliance on excessively costly medical procedures
that provide only marginal benefit, while it remains true that the political and
economic structures of their society produce unfair or unreasonable distribu-
tions of health care resources.
V. AUTONOMY

Extending stewardship beyond its primary domain will likely increase the potential for conflict between stewardship and other values. And, even when the duty of stewardship is confined to zones of discretion, some will fear that it will impinge on the rights of individuals. They will say that physicians and patients should be free to select from among the available beneficial treatment options the option that they personally favor. The right to do so follows from a due respect for their autonomy.

This is an important concern. Let us consider it first when it is pressed from the standpoint of the patient. Suppose a patient would like to receive a treatment that his physician believes should not be offered to him on grounds of stewardship. The physician explains to the patient that an alternative, and less costly option, is available and that it will be effective in treating his condition. Would the patient have an autonomy-based complaint against the physician? Not obviously; because the physician is under no requirement to engage in irresponsible medical practice at the request of her patients. Just as she does not violate her patient’s autonomy if she refuses to offer him a treatment option that she judges, with good evidence, to be ineffective, so too she would not do so when she refuses to offer him an effective, but unnecessarily costly, option. Acceding to the patient’s wishes in this circumstance would require her to violate her duties as a physician.

This reply assumes that physicians have a duty of stewardship. It claims that, on that assumption, patients have no autonomy-based claim to treatments that it would be irresponsible for physicians to provide. But matters are not so simple. Next, consider a variation on the example, one that takes us back to the skeptical view of stewardship I mentioned earlier. Suppose the patient offers to pay out of his own pocket the additional cost provided by the more expensive treatment. In this circumstance, the patient could insist that in spending more on his treatment than is necessary, the physician is not using up resources that could be used on others. The physician’s duty of stewardship, he can say, does not apply to his case. And because it does not, the physician has no good reason to deny him the treatment that he favors, and so the physician’s doing so would constitute a disregard for his autonomy.

This new objection to stewardship is instructive. If successful, it shows that the duty of stewardship applies only when the resources in question are public. Providers of privately funded health care would not be subject to the duty. A physician in the example we are considering could respond, however, that it is part of her conception of what it is to be a good doctor that she treat patients similarly, irrespective of their ability to pay for services. If it is permissible for physicians to have this self-conception, and it certainly seems that it is, then they ought to be able to act on it. For this
reason, patients would have no claim grounded in autonomy to receive the treatment that they, but not their physician, believe to be appropriate. This reply extends the duty of stewardship to all medicine, including privately funded medicine, by invoking a particular ideal of good medical practice. But because this ideal is not universally accepted by physicians and because it may not be one that physicians are required to embrace, we must allow that the duty of stewardship may not apply to privately funded medical practice in which both the physician and the patient believe that some treatment option would be best, even if it should not be provided in other contexts because of stewardship considerations.

This concession has a significant implication that we should pause to consider. In general, clinical medical duties are mandatory professional duties. They apply to medical practice as such. Duties of stewardship, however, may not be applicable in all medical contexts. If they exist, they may be bounded duties and they may not apply to all health care professionals. The reason why this would be so is that health care stewards cannot claim to have authority over all resources. They can claim only to have authority over the resources with which they have been entrusted. Private money is private money; and if patients desire to spend it, for example, on high cost/marginal benefit treatments, then considerations of stewardship do not appear to stand in the way. Perhaps this is the truth behind the skeptical view, and it points to an important, and insufficiently acknowledged, limit to stewardship in medicine.

We have been considering the autonomy objection to stewardship when seen from the standpoint of the patient. Bracketing the issue of private medicine just discussed, can the autonomy objection to stewardship be convincingly advanced by the physician? A physician may think that duties of stewardship should never impinge on the zones of discretion in contemporary medicine. In these zones, physician autonomy should be given free reign, because physicians practice medicine according to their own personal styles. This version of the autonomy objection may resonate with many practicing clinicians, but it misconceives the nature and point of medical practice. Medical practice exists to benefit patients. It is not a practice in which the personal style of the physician should take priority over the welfare of those who are served. Stewardship duties, in the areas in which they apply, are duties that serve the interests of patients, because in a world in which they are not observed, there will exist fewer social resources for treating those who are sick and injured. Physician autonomy does not include the right to set back the interests of these patients.

VI. STEWARDSHIP AND SOCIETY

Duties of stewardship in medicine, based on the account I am advancing, are primarily duties of clinical practice. They apply at the bedside. Medical
associations and professional organizations can play an important role in making these duties more definite. They can do so by articulating standards of care and by setting guidelines for practice that take considerations of stewardship into account. But do others outside of the health care professions have duties of stewardship as well? Is there an obligation on the part of society at large to assist in the responsible use of health care resources? If so, what content would this obligation have?

The answer to these questions lies in recognizing the fact that physicians, and other health care professionals, practice in a political and legal environment and that this political and legal environment can make it either easier or more difficult for them to comply with their stewardship duties. Policymakers and citizens can play a role in supporting stewardship in health care by supporting political reforms that have the effect of making it easier for clinicians to comply with their duties of stewardship. Two such reforms can be mentioned here. First, there is the hotly debated issue of medical liability reform. While there is disagreement over the extent to which the fear of medical malpractice lawsuits leads physicians to practice “defensive medicine,” and thereby to order unnecessary tests and procedures, there is little doubt that there is some such effect. By supporting reasonable reforms in medical malpractice law, policymakers and citizens can help remove fears that militate against responsible stewardship in medical practice (American College of Physicians, 2011). Second, at the payer level, insurance companies and government aid agencies can work with medical associations to develop guidelines for reimbursement that take stewardship into account. By supporting these initiatives, policymakers and citizens would help to change the financial incentives that currently encourage physicians to engage in wasteful and unnecessary medical practice (Fisher, Bynum, and Skinner, 2009; Reuben and Cassel, 2011).

Yet, as these examples illustrate, the duty of stewardship at the societal level is a secondary duty. It is a duty to assist others in meeting their duties. This is exactly what one would expect if one keeps duties of stewardship distinct from other duties, such as the duty to support just institutions, which apply more broadly to all members of society. In contrast to duties of justice, duties of stewardship apply, primarily and in the first place, to those who are designated as the stewards of the goods in question. Still, while stewardship at the societal level is not the same as justice at the societal level, there are some significant connections between the two concepts that are worth mentioning. First, on some accounts of justice—libertarian accounts, for example—all health care should be provided by the private market. As discussed earlier, in a world with no public provision of health care, there might be no medical duty of stewardship. Second, on many accounts of justice, the pursuit of stewardship will serve the cause of justice. By eliminating wasteful spending on health care, health care practitioners can make it easier for their society to provide adequate health care to all. Finally, in some
circumstances, we might judge a society to be so radically unjust in its delivery and distribution of health care that the duty of stewardship would cease to be an important concern. In these unfortunate circumstances, the duty of stewardship would remain, but it would be overwhelmed by the much more pressing need to rectify injustice.

VII. CONCLUSION

Appeals to stewardship in medicine are common, and they are likely to become more common as modern societies struggle to contain health care costs. I have argued that we should resist the impulse to use the language of stewardship to give voice to every problem that confronts contemporary medicine. Talk of stewardship in medicine will be helpful insofar as it enables us to identify duties that are not better expressed in other terms. With this in mind, I have argued that stewardship is best understood as a duty that applies in a space between the obligations of health care providers to provide beneficent care to their patients on the one hand and the obligations of citizens to bring about and support a just health care system on the other. Seen with clear eyes, stewardship in medicine is neither a consequence of beneficent medical care nor a substitute for justice.

The account of stewardship that I have presented is not the only possible interpretation of the concept. But it is one that illuminates common uses of the term and helps us to articulate more precisely and clearly the duties of physicians and other health care providers—or at least those who are involved with the provision of publicly funded health care. It has another more practical advantage as well. By separating the duty of stewardship from the duty of justice, the account shows how those who accept rival accounts of just health care can nonetheless accept a common understanding of the ethical demand on health care providers to use health care resources responsibly. In an increasingly polarized political world, a nonpolitical account of stewardship may prove to be indispensable to successful efforts to reform contemporary medical practice.

NOTES

1. One possible exception is Howard Brody. He does not use the term stewardship, but his argument that physicians and medical associations have an ethical responsibility to target and eliminate wasteful or ineffective procedures is congruent with the account of stewardship I present here. See Brody (2010).


3. In a similar vein, Fisher et al. call attention to what they term “the gray areas” of clinical decision making. See Fisher et al. (2009, 851).

4. On this, see the useful discussion of subjective and objective interpretations of the principle of beneficence in medicine in Veatch (2003, 47–51).
5. The marginal benefit in question in these cases could be either marginal benefit relative to no treatment or marginal benefit relative to some alternative treatment.

6. I thank an anonymous reviewer of this journal for pressing me on this point.

REFERENCES


