A Method in Search of a Purpose: The Internal Morality of Medicine

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ABSTRACT

I begin this commentary with an expanded typology of theories that endorse an internal morality of medicine. I then subject these theories to a philosophical critique. I argue that the more robust claims for an internal morality fail to establish a stand-alone method for bioethics because they ignore crucial non-medical values, violate norms of justice and fail to establish the normativity of medical values. I then argue that weaker versions of internalism avoid such problems, but at the cost of failing to provide a clear sense in which their moral norms are internal or can ground a comprehensive approach to moral problems. Finally, I explore various functions that an internal morality might serve, concluding with the observation that, while there may be a core of good sense to the notion of an internal morality of medicine, our expectations for it must be drastically lowered.

Keywords: external morality, internal morality, methods of ethics.

I. INTRODUCTION

Some respected commentators on medicine and morality claim that a sufficiently robust medical ethic can be derived entirely from the contemplation of medicine’s proper nature, goals, and practice (Pellegrino, 2001; Kass, 1975, 1985). For them, physicians have no need of moral values, principles or theories stemming from either common morality or, worse yet, from the fevered brains of philosophers or theologians; instead, according to this view, physicians may obtain all the moral guidance they need from a morality internal to medicine. But other equally respectable commentators contend that
there is no such thing as an internal morality of medicine (Veatch, 2001). They contend that all judgments in bioethics must be guided and ultimately justified by ethical norms external to the practice of medicine. This is indeed a curious state of affairs. How is it that equally perceptive observers of the medical scene could have come to such diametrically opposed conclusions about the most fundamental methodological question in medical ethics?

Something else is quite curious. Among the more moderate partisans of an internal morality of medicine are theorists who claim that this morality exists in a state of perpetual historical dynamism ‘in conversation’ with external moral norms derived from a wide variety of sources (Miller & Brody, 2001). These moderate internalists contend, moreover, that the successful resolution of contemporary moral problems in medicine will depend upon a judicious balancing of both internal and external moral norms. They thus deny that internalism in medical ethics can function as a comprehensive, stand-alone methodological approach. This crucial concession in effect appears to reconcile internalism with the views of one of its sharpest externalist critics (Beauchamp, 2001). How is it that this other set of equally observant proponents of rival methodological approaches could end up saying the same thing?

In this commentary I shall explore how the various participants in this debate over method can have reasonably arrived at their respective positions. I shall agree with internalists that there may well be a core of good sense in the idea of an internal morality of medicine, but I shall agree with the externalists that the successful resolution of any and all contemporary problems in bioethics will require resort to a host of moral norms external to medicine. This undertaking will require a much closer look at the typology of internalism – i.e., the various kinds of internalism that, I shall argue, have only been partially mapped by the participants in this debate. More importantly, however, it will also require a much more explicit and thorough inquiry into the various possible functions that an internal morality of medicine might serve. Against the backdrop of these analytical inquiries, I shall conclude that one likely explanation for the possible misunderstanding between the various partisans in this debate is that they have been insufficiently attentive to the point of an internal morality.

II. DEEPER INTO THE TYPOLOGY OF INTERNALISM

A review of the literature on this subject yields the following different varieties of moral ‘internalism’ in medicine:
• ‘Essentialism’, according to which a morality for medicine is derived from reflection on its ‘proper’ nature, goals or ends (Pellegrino & Thomasma, 1988; Kass, 1985).

• ‘The practical precondition account’, according to which certain moral precepts are derived as preconditions of the practice of medicine.

• ‘Historical professionalism’, according to which the norms governing medicine are decided upon solely by the practitioners of medicine – an ethic about physicians, by physicians, and for physicians.

• And, finally, an ‘evolutionary perspective’, according to which professional norms in medicine evolve over time in creative tension with external standards of morality (Miller & Brody, 2001).

**Essentialist Accounts**

Let us take a closer look at these types of moral internalism, beginning with the essentialist perspective. This is by far the most robust, but also the most controversial, of the internalist approaches. Essentialism claims, in brief, that careful reflection on the very nature of medicine as a practice, including reflection on its ends or goals, can yield a serviceable medical ethic. For example, such reflection might highlight the nature of medicine as a *healing* profession whose members *proclaim their commitment* to caring for the sick. From these basic premises, one might then move to a consideration of various practical problems in medicine, such as determining the morality of physician-assisted suicide (PAS), performing cosmetic surgery or abortion, or physicians’ obligations to dangerous or contagious patients. Some plausible applications of essentialism to such problems might, then, yield the following practical conclusions:

• Physicians have a moral duty to treat HIV-infected patients. This follows from the proposition that physicians are healers; they care for the sick and vulnerable among us. Anyone unwilling to shoulder such burdens does not know what it *means* to be a physician; or, if they do know what it means to be a physician and are yet unwilling to shoulder such a burden, then they have chosen the wrong profession for themselves.

• Physicians should not cooperate with HMO inspired mandates to ration health care at the bedside. The physician’s job is to minister to the needs of individual patients, not to solve social problems at her patients’ expense.

• Physicians should not participate in PAS. The end of medicine is to heal, cure, or alleviate suffering by licit means. Killing patients contradicts the true end of medicine.
Physicians should not perform abortions or cosmetic surgery. Such actions do not advance the above goals of medicine so they fall outside the bounds of the proper procedures physicians should perform.

This kind of internalist medical ethic derives additional specificity and strength from the very notion of a profession and the ethical duties attendant upon being a professional. In contrast to those engaged in ordinary trades, such as selling stamps or repairing auto mufflers, a professional is bound by more stringent duties than those governing contractual relations within a market economy. Because the relationship between professionals and those they serve is asymmetrical with regard to knowledge, power, and vulnerability, lawyers, physicians and nurses have a duty as professionals to subordinate their own self-interest to the welfare of their clients or patients. Combined with the traditional medical obligation to ‘do no harm’, this professional duty creates a very strong duty of fidelity or loyalty to the best interests of one’s patients (Fried, 1974).

**The Practical Precondition Account**

This approach simply amounts to asking what are the essential preconditions for the practice of medicine. It asks, in other words, what are the virtues and norms without which the practice of medicine would cease to be a going concern. This approach to the development of an internal morality seems to have been somewhat neglected both in the literature at large and in the contributions to this symposium.

A classic example of this method at work would be the acknowledgment of a duty of confidentiality in medicine. Whether or not violating patient confidences also violates the nature of ‘healing’ or of some other essential goal of medicine, it certainly makes it practically impossible for physicians to maintain a relationship based upon trust with their patients; and in the absence of trust, patients will either not disclose information vital to the healing enterprise or they will simply refuse to seek the services of a given physician. Note that this approach does not appear to commit us to speculative and controversial claims concerning the essential nature of medicine and its goals; all we need to assume is a very thin account of the goals of medicine (for example, one that assumes the desirability of an ongoing patient–physician relationship). It simply asserts that, whatever we think about medicine’s ‘true’ purposes, the enterprise of medicine as a practical activity won’t be able to get off the ground without scrupulous adherence to the duty of confidentiality.
There is an interesting and instructive analogy to this approach in Lon Fuller’s celebrated ‘internal morality of law’ (Fuller, 1969). In contrast to those who would ground the moral force of law upon some speculative scaffolding – such as might be available, for example, in Thomistic natural law theory or Rawls’s Kantian theory of justice – Fuller sought the moral bedrock of law in an account of ‘the morality that makes law possible’. So, instead of grounding law in a theory of rationality or natural human tendencies fraught with implications for the resolution of substantive problems in constitutional or criminal law, Fuller attempted to articulate a theory of the practical preconditions of successful lawmaking. Unlike Aquinas and Martin Luther King, who attacked wicked and unjust laws on the ground that they contradicted a so-called ‘higher law’, Fuller elaborated a set of eight preconditions without which law could not be successfully made in the first place. His list included the following:

- There must be rules.
- The rules must be promulgated.
- Except when necessary to remedy a past injustice, laws should not be retrospective or *ex post facto*.
- Laws should be clearly and coherently articulated.
- There should not be contradictions in the laws.
- Laws should not require the impossible.
- Laws should be maintained constant through time.
- And, finally, there should be congruence between official action and declared rule (Fuller, 1969, pp. 46–81).

Instead of viewing law through a Hobbesian-Austinian positivist lens – i.e., as an exercise of sheer power of the stronger party over the weaker – Fuller insisted on viewing law as a purposive social practice wherein citizens are given norms to shape their future conduct. Insofar as evil rulers, such as the Nazis, failed to abide by the above norms of successful lawmaking, they didn’t simply make bad laws that need not have been obeyed; rather, Fuller asserts, they actually failed to make law in the first place.

It is noteworthy that this morality has to do exclusively with the *making* of law *tout court*, and it is thus non-committal with regard to any and all more specific controversies bearing on the morality or justice of particular laws. In other words, the internal morality of law is fully in place well before we have even begun to debate the vagaries of capital punishment, affirmative action, and the economic analysis of law. Anyone who wants to make law, whether he
be Taliban, Marxist, or Christian Democrat, must first attend to the craft of lawmaking, which is strictly speaking neutral between these different ideological engines for the direction of law. The disturbing consequence of this is that a given regime might succeed in formulating genuine laws according to all eight of Fuller’s criteria while the content of those laws remained manifestly unfair and perhaps even wicked. (South Africa’s apartheid regime comes to mind.)

**Historical Professionalism**

This method of deriving an internal morality looks to the medical profession’s efforts over the course of history to define its own specific virtues, vices, and codes of conduct. In contrast to externalism’s mode of deriving duties, this approach embraces an historically evolving core of norms determined exclusively by physicians to constitute a professional morality. And in contrast to essentialism’s mode of deriving duties from atemporal essences and unchanging goals, the primary source of historical professionalism’s internal morality resides not in claims bearing on the essential nature and goals of medicine, but rather in a temporally conditioned agreement among physicians on what they consider to be right and virtuous conduct. Thus, in opposing PAS, for example, this approach would stress the medical profession’s nearly universal and historically continuous opposition to this practice stretching back to the Hippocratic Oath.

**An Evolutionary Perspective**

Miller and Brody deploy what is, to my mind at least, the most plausible and attractive model of medical internalism advanced so far. Eschewing both the Platonic essentialism of Pellegrino’s account and the historicism of a purely social constructionist view of professional morality, Miller and Brody propose a theory of professional medical goals and duties conditioned by the evolving demands of history and (external) social/cultural influences. They thus want to argue that there is indeed a core ethic developed on the basis of reflection on medicine’s specific goals and duties, but that this core ethic develops historically as a result of a dialectic or conversation between the medical profession and the larger society.

One interesting feature of this evolutionary internalism is its openness to historical change and development in the received core values, goals and duties of medicine. There is no reason whatever to believe that medicine exhibits some eternal essence, unmodified by time, place and culture. Miller and Brody (2001)
are thus open to the acknowledgment of new goals and duties – for example, the prudent shepherding of society’s medical resources under conditions of fiscal scarcity – and to the reinterpretation of the relative strength or importance of existing elements of the internal morality. An example of the latter phenomenon, the authors assert, is their own embrace of PAS based upon a reinterpretation of the relative weights of the traditional admonitions not to kill, on the one hand, and to relieve pain and suffering, on the other.

Another noteworthy feature of this approach is its frank acknowledgment of the interaction between medical values and (external) social norms and influences. The very idea of an unchanging essence of medical practice unaffected by the vagaries of history and culture as it meanders through the ages is, to modern sensibilities at least, rather implausible on its face. Miller and Brody’s (2001) evolutionary account embraces the idea that the morality of medicine is always forged in a dialectical relationship with the surrounding (external) worlds of common morality, law, commerce, technology, and so on. This concession to the claims of externalist morality permits a much more satisfying explanation of the gradual development of various medical norms, such as the duty to treat dangerous or contagious patients. Whereas the essentialist account would have us believe, implausibly, that a timeless ‘duty to treat’ derives entirely from reflection on the goals of medicine, this evolutionary approach would be much more sensitive both to historical accounts of physicians’ behavior in time of plague and to the changing social expectations of physicians. It would note, for example, that in many previous historical epochs physicians basically served rich patrons. Should the plague strike a city, physicians (like Sydenham) would traditionally decamp to the countryside with their patrons, leaving their ordinary patients behind. Sometimes citizens would be highly critical of physicians who abandoned their posts, but there was by no means a single, unitary norm governing the behavior of physicians through the ages (Arras, 1988).

Such an account would also note how the duty to treat was forged in part as a response of the medical profession to the expectations of society. In an era when only the rich could expect help from physicians or when medicine as we know it existed side by side with a plethora of alternative approaches to health and disease, we should not expect physicians to conceive of a rigorous duty to treat all in need. But this is just what we would expect, for example, in the contemporary era when health care is nearly universally regarded as a social need akin to fire and police protection, and when various licensing provisions have given physicians a de jure monopoly on treating the sick. Indeed, the
dialectical interplay between the duty to treat and licensure is quite striking in the modern era. In exchange for the exclusive and legally enforced privilege to practice medicine, physicians have (largely voluntarily) assumed the responsibility to treat all in need, including patients with contagious diseases. Thus, the duty to treat is best viewed as neither a pure internal duty nor as a purely externally imposed norm; rather, it is the concrete, historically determined outcome of a dialectic between medicine’s internal morality and a host of social expectations.

III. PUTATIVE FUNCTIONS OF AN INTERNAL MORALITY OF MEDICINE

Having briefly surveyed the various candidates for an internal morality of medicine, we come now to the question of what might be reasonably asked of any such approach. What, in other words, is an internal morality of medicine for? One salient answer, which seems to provide a shared implicit premise of the essays both in this symposium and in the literature at large, is that medical internalism should provide us with the tools we need to resolve important issues in bioethics, such as abortion, PAS, confidentiality of genetic records, the duty to treat AIDS patients, and so on. I shall argue, on the contrary, that medical internalism either cannot satisfactorily perform this function or, if it can, it must give up its claim to be a species of internalism. I shall also argue that there nevertheless remains another function of medical internalism – a product of professionalism in general and the practical precondition account – that is both legitimate and important. In brief, I shall side with Robert Veatch (2001) and Tom Beauchamp (2001) on the question whether an internal morality of medicine is useful for contemporary bioethics (No, it’s not), but I shall also side with Ed Pellegrino (2001), Frank Miller and Howard Brody (2001) on the question whether such a morality exists and can perform a valuable service for physicians.

Problem-Solving with an Internal Morality of Medicine

I begin with my negative thesis – viz., that none of the versions of internal morality thus far surveyed will prove useful in the resolution of contemporary bioethical problems or, if one or another does prove useful, it thereby ceases to be a bona fide version of internalism. Let us begin with Pellegrino’s essentialism.
Essentialism

As a number of commentators have pointed out, among them Miller and Brody, essentialist internalism is a non-starter for several reasons. First, in spite of its advocates’ best efforts (Pellegrino & Thomasma, 1988, p. 214), certain indispensable elements of contemporary medical morality, such as a duty to obtain the informed consent of patients, simply cannot be derived from an analysis of the concept or primary goals of medicine. As legions of physicians correctly but futilely complained during the protracted legal battle over informed consent in the early 1970s, the doctrine of informed consent did not grow organically out of the very practice of medicine, but rather was imported from the decidedly hostile camps of law and liberal political philosophy (Katz, 1984).

Second, this kind of essentialist internal morality lacks the resources to determine the limits of (or resolve conflicts among) norms that might, for the sake of argument, be postulated to belong to this internal morality. Three likely candidates for this status are the duty of confidentiality, the proscription of active killing, and the duty to alleviate suffering. As for confidentiality, even if it can be shown that such a duty belongs to this internal morality (more on this below), that morality by itself is incapable of determining the strength and limits of this duty as it collides with other, clearly external obligations to other parties. If we agree that psychiatrists have a ‘duty to warn’ third parties of their patients’ credible threats of violence, our agreement is premised upon considerations having nothing to do with the nature and goals of medicine, but everything to do with the protection of vulnerable others. Here the prerogatives of equal citizenship and common decency show the way, not deeper reflection into the heart of medicine.

With regard to the proscription of killing and the duty to alleviate suffering, defenders of essentialist internalism must come to terms with the possibility of head-on conflict among internally generated norms. We have already seen how the condemnation of PAS and euthanasia can be derived from the physician’s profession as a healer (“We’re doctors, we heal; we don’t kill”), but we must now contemplate the possibility that a positive duty to aid patients in their own suicides may with equal plausibility be derived from physicians’ obligation to alleviate pain and suffering. Just as physicians have a moral duty to prescribe effective pain killers for patients following surgery, so they may in certain extreme situations, when all other alternatives have failed, have a duty to help patients overcome their intractable suffering by means of a mercifully delivered prescription of lethal dose. If Miller and
Brody are correct, either reading of the internal morality of medicine is plausible, but they cannot both be true at the same time and place. In order to adjudicate the conflict between these internal norms, we will have to appeal to values, principles and norms outside of the medical sphere. (For example, the principle of self-determination.) There is no clearly articulated hierarchical principle within medical morality, so defined, that could settle this debate on purely internalist terms.

Internal Morality as Practical Precondition

As we saw above in our account of the legal analogue of this kind of internal morality, viz., Fuller’s ‘morality that makes law possible’, an internal morality of law is really more akin to a theory of legal craftsmanship than a critical moral theory. It tells us what judges must do in order to successfully make law, whether the laws we wish to make pertain to the mandatory destruction of graven religious images, the restoration of property to the proletariat, or entitlements under the welfare state. Fuller’s internal morality of law is not only fully in place before we get to the question of law’s substantive morality, it is also of little, if any use in the resolution of that question in the context of debates over problematic laws and governmental policies. Presumably, in order to make progress in our familiar debates about affirmative action, the death penalty, and so on we will have to invoke one or another explicitly external morality of law, whether it be the common law, Thomistic natural law theory, legal realism, a Rawlsian theory of fairness, Marxism, the Koran, or some other approach. Thus, Fuller’s theory of an internal morality of law can only help us determine how to actually create law as a responsive social interaction between those who make law and those governed by it. The actual content or direction of law can only be settled by appeal to various moral sources external to law.

The practical precondition approach to internal medical morality differs somewhat from Fuller’s legal analogue because some of the things that ‘make practicing medicine possible’ – for example, the duty of maintaining patients’ confidentiality – are also elements of substantive morality that figure in contemporary bioethical debates. Whereas Fuller’s internal morality of law cannot help us decide among rival but indisputably law-like solutions to problems in the various branches of law, medical internalism harbors norms, such as ‘do no harm’, and ‘keep confidences’, that are at least relevant to many practical problems. This advantage over Fuller’s version of internalism ultimately proves insufficient, however, for two reasons.
First, the indisputably action-guiding norms inherent in this version of internalism, such as confidentiality, may be valued by patients and society at large for other reasons than those given by internalism, and this may have implications for the resolution of problems at both the bedside and policy levels. As we have seen, this version of internalism values the duty of confidentiality in purely instrumental terms—viz., as a norm that makes the practice of medicine possible. Although this is certainly a crucially important consideration, it completely ignores other explanations for the importance of confidentiality based upon patient-centered values, such as self-determination and privacy. Thus, internalism may enjoin physicians to do the right thing for the wrong reason—or at least for an incomplete set of reasons—or, on some occasions, the medial practice-centered account of confidentiality may yield different conclusions than a more patient-centered or philosophical account. An example of the latter type of problem would be the challenge to confidentiality posed by the sexually active yet irresponsible HIV-infected patient. Whereas a medical practice-centered approach would most likely enjoin physicians to maintain strict confidentiality in such cases, on the ground that violations of confidentiality will disrupt the physician-patient relationship, other approaches might contend that patients who demand confidentiality while recklessly exposing others to a lethal disease thereby contradict themselves—i.e., autonomy is good for them, but not for others—and thus prove themselves undeserving of the full protection of medical confidentiality (Gillett, 1987).

Another even more serious problem threatens to undermine this practical preconditions approach. A set of norms must not only be relevant to the resolution of practical problems; it must, in addition, harbor the requisite resources to provide for the specification and balancing of competing values. Although the value of confidentiality is certainly highly relevant to many bioethical disputes today, in order to solve those problems internalism would have to take into account a plethora of external considerations, including externally articulated moral and political norms bearing on the protection of third parties and the public’s health. Since it cannot do this and remain an internal morality, the practical precondition account of internalism cannot function as a useful guide to contemporary bioethical problems.

**Historical Professionalism**

If internalist essentialism founders because it attempts, somewhat preposterously, to plane above the contingencies of history and culture, then historical
professionals fail because it never rises above the level of the guild towards a genuine ethics. Founded upon historically contingent understandings of the nature of medicine and its goals, this kind of moral internalism is notorious for giving medicine a bad name.

Note first that historical professionalism is an internal morality in a sociological sense. A particular group of people – physicians – define an ethic to govern their own conduct in splendid isolation from the norms governing the rest of society. As we shall see momentarily, this disjunction between the medical and all other sources of morality (e.g., religious, legal, customary, etc.) creates enormous problems for historical professionalism, but I want first to stress the point that this kind of isolationism also has a tendency to give rise to a kind of guild mentality that mistakes economic self interest for morality. A classic case in point is the American Medical Association’s longstanding, but now legally defunct, opposition to advertising. Prior to 1981, the AMA condemned any and all varieties of advertising on the part of physicians as grave violations of the most sacred tenets of medical morality. Although there was no doubt something to be said for this stance as a bulwark against the encroachments of a kind of sleazy self-promoting commercialism (“Come on down!”), the law and ordinary patients have tended to view it as a classic case of restraint of trade, motivated at least in large part by concern for physicians’ incomes.¹

The salad days of historical professionalism are obviously those epochs in which there is fundamental harmony between the internally derived medical ethic and external social values. (Is Doctor Welby in the house?) Severe problems arise, however, whenever individuals and groups in the larger society call into question medicine’s understanding of its own proper nature and goals. When these outsiders begin asking “Why?”, the professionally derived internal morality of medicine begins to appear reactionary at worst, or, at best, merely quaint. When the partisans of this internalism fail to acknowledge the widening gap between their own deeply held norms and those of the rest of society, their thunderous pronouncements, although taken seriously at the time, usually end up years later sounding preposterous or even comical. Here are three representative cases in point; scores of other examples could easily be provided.

- En route to coercing Dax Cowart to accept surgery, one of his physicians, Dr. Duane Larson, declares that he has “the knowledge and the means of caring for this patient so that he does survive, and you’re asking me not to
do this. Why am I in medicine?" (Andersen, Cavalier, & Covey, 1996). Now, nearly 30 years later, this physician is universally portrayed in introductory bioethics courses as Exhibit A of an overweening and unethical paternalism.

- At the dawn of the women’s liberation movement, breast cancer surgeons routinely imposed the radical and disfiguring Halstead mastectomy on their patients, refusing even to discuss less aggressive measures. Dr. Jerome Urban of the Memorial-Sloan Kettering Memorial Hospital in New York imperiously declared that “Lesser surgery is done by lesser surgeons.” (Lerner, 2001, p. 78). Defenders of the status quo in medical ethics mocked those surgeons who would disclose their uncertainties to patients and give them a share in decision making (Laforet, 1976). Again, thirty years later, physicians are legally obliged to obtain the consent of such patients following a frank and comprehensive discussion of the various alternative procedures and their respective risks and benefits. True/False examinations for board certification in surgery today would count those aggressive surgeons of the ancien régime as having given the wrong answer.

- During the comparative clinical trials of the clot busting drugs, Streptokinase and tPA, a physician declares that his duty as a physician is to give his patients the best proven drug, irrespective of cost—even if tPA proved to be only a fraction of a percentage point more effective in preventing repeat heart attacks at a cost of roughly $2,000 more per patient (Brody, 1995). Now, roughly 10 years later, this kind of insouciance with regard to the financial consequences of medical choices is widely regarded as a case study in irresponsibility and injustice to the other citizens of the medical commons.

The root problem here for this species of internalism is its obliviousness to values that have come to occupy center stage in the wider society. In these cases those key values are self-determination and equity in the distribution of health care resources. One important consequence of this detachment of internalism from the wider world of values and norms is that it puts physicians in the position of unilaterally making health care decisions that, from the perspective of this wider world, they have no right to make. Although Dax Cowart’s physicians saw themselves as answering to the highest standards of medical morality, Dax and the rest of us object that their unilateral imposition of unwanted treatment on him constituted a violation of his ethical and common law rights of autonomy and bodily integrity. And although an HMO physician might proudly proclaim her allegiance to an “ethic of loyalty” to
patients by ordering a hugely expensive drug with only a scintilla of additional benefit over the cheaper standard of care, her superiors are now likely to remind her that she does not own the resources that she dispenses so freely, and that she therefore has no right to make unilateral decisions that adversely affect the medical commons (Morreim, 1995).

Finally, the historical professionalism approach to internalism faces an insuperable problem of moral justification. As we have seen, the duties acknowledged within this kind of medical morality are grounded in an agreement among physicians about the proper goals of medicine; and we have seen that, in contrast to essentialism, the contents of this agreement are subject to historical change. Now, although it might make a great deal of sense for a profession or any voluntary organization to have its own code of behavior to govern the behavior of its members, as soon as the behavior of such a group becomes, to use Mill’s phrase, ‘other regarding’ in the sense that it impinges on the interests and lives of others outside the group, a major problem arises. For those outside of the group – in this case, the world of patients and those who pay for health care through insurance premiums or taxes – the mere fact that physicians have agreed on a set of duties does not suffice to justify physicians’ behavior based upon those duties. Indeed, for every instance of professional agreement one can raise the question, “Yes, that’s what physicians have agreed on, but is it right?” Another way to state this problem is to claim that medical internalism so defined commits the so-called naturalistic fallacy of attempting to derive an “ought” from an “is.” The bottom line here is that codes of professional conduct are not self-justifying. They must be subjected ultimately to moral and political standards of justice, however those might be defined. Many elements of professional codes will no doubt prove consistent with such standards. Even those elements that might initially seem to contradict standards of impartiality and universality, such as physicians’ traditional ethic of loyalty to their patients, might ultimately be justified by the just apportionment of different roles to different social institutions. But other norms of professional behavior – such as physicians’ longstanding reluctance to inform patients of their diagnosis, prognosis, and alternatives – will be found wanting by external norms of justice. Historical professionalism, then, proves utterly insufficient as a source of solutions to practical problems in bioethics and health policy.

The Evolutionary Account

We have seen how the evolutionary approach of Miller and Brody represented a distinct advance over Pellegrino’s essentialist version of internalism.
Whereas the latter’s theory yields a set of medical duties *sub specie aeternitatis*, this updated version of internalism embraces history and the gradual evolution of an internal ethic based upon medical goals and duties. Significantly, Miller and Brody also embrace the need to complement internalism with values and norms derived from external sources. They argue, in effect, that the ethic we actually bring to the resolution of practical problems should represent a fusion of internal and external elements. This move will enable their more expansive and eclectic theory to successfully resolve most of the problems that embarrassed all of the other versions of medical internalism. Thus, in contrast to both the practical precondition and historical professional accounts, the evolutionary model opens medical ethics up to the full range of external values and norms and, in so doing, it transcends internalism’s chronic failures with regard to both justification and the specification of duties.

Unlike all other variants of internalism, the evolutionary model cannot be criticized for ignoring crucial external values, such as self-determination, or for attempting to base medical ethics on the mere fact of physicians’ agreement on a set of duties. The evolutionary account also provides internalism with the requisite resources to effectively delimit the scope and limits of various internally developed duties. Here again, the duty to treat provides an apt case in point. Assuming it’s true that reflection on the nature and goals of medicine could somehow deliver the conclusion that physicians have a duty to treat contagious patients, neither the essentialist nor the practical precondition accounts could advise physicians on the limits of this duty. Must physicians expose themselves to any and all risks encountered in the course of their practice? Are some risks too great, or is the likelihood of their occurring too certain, to charge physicians with a duty to expose themselves to them? If physicians have a duty to be moderately courageous, do they also have a duty to become martyrs for medicine? Answers to such important questions will not be found through abstract inquiries into the nature of medicine and its proper ends. Instead, we will have to look to history and culture to determine the levels of risk that have been expected of various professional groups such as police officers, firefighters, and physicians at various times and places. Because it is prepared to acknowledge the role of such social expectations bearing on the medical profession, the evolutionary account of internal morality can succeed where the other internalist accounts failed.

Evolutionary internalism’s success in overcoming these persistent problems has been purchased, however, at a very high price. I now want to argue
that this theory has been able to avoid the traditional pitfalls of internalism by abandoning internalism itself. In other words, its victories on the fronts of specification and justification have been entirely Pyrrhic. This is so for two reasons: (1) Evolutionary internalism has given up any claim to being a comprehensive method of bioethical problem solving, and (2) the substantive content of internalism proper has become virtually impossible to identify.

In contrast to all other species of internalism, Miller and Brody’s evolutionary account no longer pretends to offer a fully comprehensive morality for physicians and policymakers. Thus, anyone wishing to come to terms with a specific bioethical problem – e.g., PAS – must bring two distinct sets of tools to the task. First, she must deploy an account of the proper goals and duties of medicine and physicians, and then she must supplement this account with values and norms drawn from such external sources as common morality and the common law. From the former she will perhaps derive the notion that physicians have a duty to relieve pain and suffering (although she may also find there a centuries-old prohibition of killing), while from the latter she may deploy the duty to honor patients’ self-determination. Now, although this eclecticism obviously doesn’t disqualify Miller and Brody’s theory as a serious and potentially helpful moral methodology, any more than the putative incompleteness of virtue ethics or casuistry disqualifies these methods as important guides to the moral life, it does largely signify that these authors are throwing in the towel on a key issue that has divided internalists and externalists – viz., whether an internal morality is sufficient to guide the moral lives of physicians.

Supposing, then, that evolutionary internalism proposes a fusion of internal and external sources of morality en route to a fully rounded and comprehensive method for bioethics. The question, however, remains: What is the distinct contribution of the internalist element to this larger, more holistic method? In what sense, exactly, does their approach remain internalist? If Miller and Brody still wish to insist that internalism can help resolve practical moral problems, we first need to know what exactly constitutes the internalist phase of the method. Their answer to this question seems to be just this: The internal element of any moral analysis is that part concerned with the proper goals and duties involved in the practice of medicine. So, to use the authors’ most explicit example, an analysis of PAS can be factored into an internal and external component; the former having to do with relief of intractable pain and suffering, and the latter with citizens’ moral rights to self-determination and legal rights to ‘privacy’. But now a problem arises: If Miller and Brody do not view their internalism as a comprehensive method of moral analysis, if they in
fact view their ultimate moral norms as the offspring of a fusion of internal and external elements that have slowly evolved and intertwined over time, then the precise determination of what’s internal and what’s not in any moral analysis will be extremely problematical. This is because what at any given time physicians consider to be the proper goals and duties of medical practice will itself already be the product of a dialectical interaction of internal and external social forces. Recall in this connection how the exact contours of the duty to treat have been shaped by social expectations and licensure statutes, and how physicians’ notion of the proper scope of confidentiality has been informed by legal expectations and philosophical applications of the harm principle. So what emerges from Miller and Brody’s account is a rather formal conception of an internal morality as that aspect of morality having to do with medical goals and duties, a conception whose actual content will always be a product of a complex and historically evolving interplay between ‘internal’ and ‘external’. If this suspicion turns out to be correct, then it will be extremely difficult, if not impossible, to assign a reliable content to what’s internal about any particular morality. And if this turns out to be the case, then it becomes fairly vacuous to speak of the contributions of an internal morality to the resolution of practical problems in bioethics.

Perhaps the most interesting test case for this interpretation of Miller and Brody’s internalism is their handling of PAS (Miller & Brody, 1995). Although they concede that both internal and external sources of moral analysis are available on this question, they suggest that an internalist approach can make a valuable and independent contribution to its proper resolution. If they are right about this, then we may have more reason to hope than I’ve admitted that an internal morality can be a useful tool in resolving bioethical problems. Their story goes like this: Although for centuries the Hippocratic admonition against killing has dominated the discussion of euthanasia, we are now in a position to see that other medical values, such as the duty to ease the suffering of patients in intractable pain and suffering, might finally tip the scales of moral judgment in the other direction. Viewed from this angle, writing a prescription for a lethal dose (or administering it oneself) can be interpreted as an act falling at the far end of a continuum of actions taken to ease the sufferings of humanity. Thus, the case for PAS can be made to rest exclusively on a basis of (internal) medical values and norms. Miller and Brody then proceed to contrast this internalist account of PAS with the typically externalist accounts of liberal political philosophy (Dworkin, 1993) and the legal right to privacy. Whereas these latter approaches stress
the notion of a right to PAS, their internalist account forswears any and all appeals to rights in favor of a purely internalist interpretation of PAS as a last-ditch attempt to relieve patients of interminable and intractable suffering. This then is an ideal test case for their theory because they see it as vindicating the notion of a content-full internal morality.

I am not yet persuaded. My skeptical instincts lead me to ask, “Why now? Why, after all these centuries of loyal and heartfelt obedience to the Hippocratic proscription of killing, should physicians suddenly come to see that a permissive case for PAS can actually be constructed out of elements heretofore marginalized within physicians’ own internal morality?” My tentative answer to this question is that entirely external challenges to physicians’ traditional ethic have altered the usual balance between the perceived value of not killing and the value of alleviating suffering. Importantly, these challenges and altered weights have owed much more, I would suggest, to social phenomena such as the recent decline of medical authority, the rise of consumerism and patients’ rights movements, and to a robust conception of patient self-determination than they owe to physicians’ sudden discovery that really, when you come right down to it, the alleviation of suffering can be more important on occasion than worries about killing patients. In other words, my hunch is that Miller and Brody’s current sense that a proper appreciation of medical values now permits PAS in rare instances is largely if not entirely the product of external societal forces impinging on traditional medical values, forces that motivate physicians (finally) to assign greater weight on occasion to alleviating suffering and less to avoiding killing. And if this hunch is correct, then even Miller and Brody’s best case for the practical usefulness of a purely internal morality of medicine turns out to be largely a product of externalist influences. And if this is so, then there isn’t much left to the notion of an internal morality of medicine that can help us solve current bioethical problems.

An Alternative Function for an Internal Morality

Instead of viewing internalist medical morality as a guide to the resolution of substantive moral problems, I propose that we attempt to vindicate internalism by assigning it a more modest function. But given my skepticism about whether the Miller–Brody account is really an internalism in any robust sense, a word might be in order about how I construe the internal morality of medicine. Although I do not have a well worked out theory on this subject, I do have some very rough ideas about what elements might go into such an ethic:
Borrowing a page from Fuller’s practical precondition approach, we can say that the internal morality of medicine will emphasize those duties (like confidentiality) that help to make the practice of medicine possible.

This ethic will also incorporate traditional maxims that might not take us very far as guides to solving moral problems, but are nevertheless useful as general rules of thumb – e.g., ‘Do no harm’. One corollary of this maxim is that physicians are not supposed to sacrifice the interests of their patients to those of society at large.

Finally, this ethic will adopt a set of fiduciary responsibilities derived from the role of professional. Given the significant disparities of knowledge and power between physicians and their patients, and given patients’ resulting vulnerabilities, physicians assume a strict duty to place the welfare of patients ahead of their own financial (or other) interests.

This is just a start, and I’m sure that others could flesh out this list better than I can. Still, it sets us on the right path towards a much more modest account of the internal morality of medicine. The proper function of this morality is not to solve problems, but rather to give physicians an identity as professionals, rather than as self-interested tradespeople, and a basic education in some key medical virtues (e.g., courage, compassion, truthfulness, etc.) As Pellegrino and Thomasma suggest, this foundation for medical morality is ‘necessarily antecedent’ to whatever position may be taken in specific moral dilemmas (Pellegrino & Thomasma, 1988, p. 219). The take-home lesson of this investigation into moral internalism is that it’s possible to have an internal morality of a professional practice that is at once meaningful (as a set of preconditions for the practice itself) and yet also completely inadequate (as a guide to the resolution of current practical problems).

Thus, contrary to Robert Veatch’s conclusion that an internal morality of medicine is ‘impossible’ – typical Veatchian hyperbole! – we can now see how such a morality is indeed possible (as a general orientation towards the virtues necessary to practice medicine) without being of much, if any assistance in helping us resolve knotty moral problems in medicine. The key, as with so much else in this life, is to lower one’s expectations.³

NOTES


3. I would like to thank Robert A. Crouch for his help with the argument and with the manuscript.

REFERENCES


