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The Internal Morality of Medicine: A Constructivist Approach

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Abstract: Physicians frequently ask whether they should give patients what they want, usually when there are considerations pointing against doing so, such as medicine's values and physicians' obligations. It has been argued that the source of medicine's values and physicians' obligations lies in what has been dubbed "the internal morality of medicine": medicine is a practice with an end and norms that are definitive of this practice and that determine what physicians ought to do *qua physicians*. In this paper, I defend the claim that medicine requires a morality that is internal to its practice, while rejecting the prevalent characterization of this morality and offering an alternative one. My approach to the internal morality of medicine is *constructivist* in nature: the norms of medicine are constructed by medical professionals, other professionals, and patients, given medicine's end of "benefitting patients in need of *prima facie* medical treatment and care." I make the case that patients should be involved in the construction of medicine's morality not only because they have knowledge that is relevant to the internal morality of medicine—namely, their own values and preferences—but also because medicine is an inherently *relational* enterprise: in medicine the relationship between physician and patient is a constitutive component of the craft itself. The framework I propose provides an authoritative morality for medicine, while allowing for the incorporation, into that very morality, of qualified deference to patient values.

Keywords: Philosophy of Medicine; Values in Medicine; Internal Morality; Constructivism; Physician-Patient Relationship; Patient Involvement

1. Introduction

Physicians frequently ask whether they should give patients what they want, usually when there are considerations pointing against doing so. Consider the following example. A patient comes to a surgeon requesting that her left leg be amputated above the knee. She says that her left leg has always felt "alien" to her and that her life would be much better without it. Indeed, she compares herself to a person who feels he or she has been born in a body of the wrong gender and wants an operation to put things right, to be "whole." The patient has brought a letter from her psychiatrist that states that she has full decision-making capacity. Should the surgeon perform the operation?[1] On the one hand, giving this patient what she wants honors the value of respecting her autonomy—this is what she, as a competent agent, wants—as well as her values and epistemic authority over them. On the other hand, not giving the patient what she wants honors other sources of values, such as medicine's values and physicians' obligations. It has been argued that the source of medicine's values and physicians' obligations lies in what has been dubbed "the internal morality of medicine": medicine is a practice with an end and norms that are definitive of this practice and that determine what physicians ought to do *qua physicians* (or, stated in non-deontological terms, that determine what it is for physicians to excel in the craft of medicine). However, answers to questions such as how to determine the internal morality of medicine, as well as how to incorporate societal values and patient values into this morality, have proven to be elusive. Having answers to these questions is crucial if physicians are to justify to themselves, to their patients, and to society at large, why they will not give a patient what he or she wants when it contradicts what physicians are obligated to do (or not to do) in their role as physicians.

[1] I am indebted to Daniel Brudney for this example.

My aim in this paper is to defend the claim that medicine requires a morality that is internal to its practice, while rejecting the prevalent characterization of this morality and offering an alternative one. My approach to the internal morality of medicine is *constructivist* in nature: the norms of medicine are constructed by medical professionals, other professionals, and patients, given medicine's end of "benefitting patients in need of *prima facie* medical treatment and care." I make the case that patients should be involved in the construction of medicine's morality not only because they have knowledge that is relevant to the internal morality of medicine—namely, their own values and preferences—but also because medicine is an inherently *relational* enterprise: in medicine the relationship between physician and patient is a constitutive component of the craft itself. The framework I propose thus provides an authoritative morality for medicine, while allowing for the incorporation, into that very morality, of qualified deference to patient values. I proceed as follows. I first explain the nature and importance of the internal morality of medicine (section 2) and discuss dilemmas, motivations, and objections associated with the idea of a morality that is internal to medicine (section 3). I then present my own constructivist approach (section 4) and make the case for patient involvement in the proposed constructivist procedure (section 5). Finally, I explain how my internalist approach to medicine's morality can deal with the main challenges to more traditional internalist approaches (section 6).

2. The Nature and Importance of the Internal Morality of Medicine

Why is an internal morality of medicine needed? A good starting point in attempting to answer this question is the growing recognition that medicine is a *normative* or *value-laden* enterprise. When paternalistic models of the physician-patient relationship, which place little importance on patient autonomy, fell out of favor several decades ago, fact-provider models, which champion

patient autonomy, seemed like a promising alternative. According to the latter models, physicians merely provide patients with non-value-laden medical information and patients then choose their preferred intervention based on their own values. However, it was soon realized that the assumption underlying these models, according to which there is a clear distinction between facts and values, is untenable: physicians cannot really avoid making value judgments. Moreover, patients do not necessarily possess fixed and known values and can make choices that frustrate their own values (Emanuel & Emanuel 1992; Savulescu 1995). Given such problems, as well as growing recognition that medical decision-making should be shared by patient *and* physician, models that give a key role to physicians' value judgments emerged. According to these models, physicians deliberate together with patients regarding the best health-related values that could, and ultimately should, be pursued in the clinical situation (Emanuel & Emanuel 1992, p. 2222).[2] If medicine is in fact a value-laden enterprise and physicians advocate for certain values, there is the further question of the *source* of these values. One possible way of answering this question is via what has been dubbed "the internal morality of medicine," where the term "morality" simply denotes a certain set of norms and values that are specified by their content.[3]

The idea that there is a morality that is "internal" to a certain practice was first developed in the realm of law rather than medicine. In particular, Lon Fuller (1969) argued that there are standards that need to be satisfied for the law to function properly, for example, laws need to be public, stable, and non-contradictory. Not satisfying these standards would lead to a violation of

[2] There are variations on these models in the literature. For example, Savulescu (1995) argues that physicians should make all-things-considered value judgments: physicians form a conception of what is best for their patients and rationally argue with them (without coercing patients). He calls this "rational non-interventional paternalism."

[3] In debates about medicine's morality, the term "morality" does not denote specifically "moral imperatives" that command categorically. Moreover, physician obligations are broadly-construed professional obligations rather than distinctively moral obligations. Therefore, following Williams's (1985, pp. 174-196) distinction between "morality" and "ethics," the name "the internal *ethics* of medicine" would have been a more appropriate title for the project. This would have had the virtue of not suggesting a closed "morality system." However, since the project is known as "the internal morality of medicine" in the literature, I will use this language throughout the current paper.

the internal morality of law and a thwarting of law's end: the well-functioning of society. John Ladd was the first to follow in Fuller's footsteps and apply the idea of an internal morality to medicine. In particular, Ladd (1983, p. 210) argued that medicine embodies a body of norms that he called "the internal morality of medicine," for example, "professional norms condemning unnecessary interventions," "norms condemning unorthodox treatment […] and condemning the use of certain medical procedures for non-medical purposes," and "norms relating to the prescription of drugs." These norms dictate obligations that bind physicians simply by virtue of the fact that they are members of the medical profession. Ladd did not take a stand on the identity of the end(s) of medicine and believed that the importance of these norms is independent of such an end or ends. Indeed, he hoped that specifying the norms that constitute the internal morality of medicine might help in determining the end(s) of medicine. While this framework is supposed to parallel Fuller's framework for law, Fuller's system included an end: the well-functioning of society. Thus, the success or failure of the implementation of the internal norms can be assessed insofar as they further (or are at least consistent with) this end. Furthermore, a clear end to the practice can unify the norms of its internal morality into one coherent whole.

Given the importance of finding an end to medicine, it is perhaps not surprising that the more prominent manner in which the idea of an internal morality of medicine has been developed is by way of a *teleological* account; that is, by conceptualizing the internal morality of medicine relative to an end that is definitive of the practice of medicine. The idea that medicine has an end was championed by Leon Kass (1985, p. 174), who argued that "health" is the end of medicine, which amounts to "the well-working of the organism as a whole" or "an activity of the living body in accordance with its specific excellences." Edmund Pellegrino—at times together with David Thomasma—has developed this idea into a teleological account of medical practice

and its internal morality. First, he argues that the end of medicine—generally understood as "a right and good healing action for a particular patient" (Pellegrino and Thomasma 1981, p. 219)—is not a social construction, but rather the "real [...] definition" and "essence" of medicine (Pellegrino 1999, p. 61). Second, Pellegrino ties the idea that there is a definitive end to medicine to the idea that this end determines, in conjunction with certain standards of excellence, goods that are internal to medicine as well as physicians' obligations (Pellegrino 1999, pp. 63-64 & 2001a, p. 171). He does so by utilizing Alasdair MacIntyre's conception of a practice.[4] According to MacIntyre (2007, p. 187), a practice is a "coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realized in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity." In other words, entering into a practice entails both the acceptance of the authority of certain standards of excellence that partially define the practice and the attainment of certain goods. MacIntyre (2007, pp. 188-190) calls these goods "internal," as they cannot be had independently of the practice and are only realized when trying to attain the standards of excellence that define the practice. External goods, on the other hand, are contingently attached to the practice by social circumstance. Thus, excellence in healing is an internal good of medicine, while making money is an external good (Pellegrino 2001b, p. 562).

Finally, we should add two more key ideas to this teleological account. First, as Pellegrino (1998, p. 327) notes—following MacIntyre's (2007, p. 193) position that practices are not to be identified with mere technical skills—"medicine *qua* medicine comes into existence when it appropriates knowledge and skills […] in order to further its healing purposes." In other words,

[4] Pellegrino utilizes MacIntyre's conception of a practice—as well as the associated concept of "virtue," which I discuss below—throughout his work; see, for example, Pellegrino & Thomasma (1988 & 1993) and Pellegrino (2001b).

physicians' knowledge and skills are not to be conceptualized independently of medicine's end. Rather, the end of medicine shows how physicians' knowledge and skills are inherently tied to medicine's values. Second, MacIntyre (2007, p. 191) ties his conception of practices to the concept of "virtue": "*A virtue is an acquired human quality the possession and exercise of which tends to enable us to achieve those goods which are internal to practices*." A *good* physician is thus not merely a good technician, but someone who has acquired the virtues needed to attain the goods and further the values of medicine. Therefore, the position that there is a morality which is internal to medicine aims to capture the following idea, which I shall refer to as "Fundamental Idea":

> **Fundamental Idea** Medicine is a practice that is governed by an end that is definitive of it and by standards of excellence that are internal to the type of activity that it is. This end and these standards determine the goods that cannot be had independently of the practice as well as the obligations of physicians who partake in the practice. Moreover, the successful employment of physicians' knowledge and skills cannot be dissociated from having medicine's end and standards of excellence in view: they unify physicians' knowledge and skills, as well as medicine's values, into one coherent and intelligible activity. A good physician is one who has not merely mastered knowledge and skills, but who has the virtues that allow him to attain the goods and further the values that are internal to the practice of medicine. He is, in short, a competent medical craftsman.

"Fundamental Idea" explains the unification of medical techniques and values into a coherent and intelligible whole in a way that determines physicians' competence qua medical craftsmen.

3. Internalism versus Externalism about Medicine's Morality

When Pellegrino (1999, p. 55) made the case for his internal morality of medicine, he set up the following dilemma: either the ends of medicine are "*internal* to medicine itself" or they are "set *externally* by some form of social construction, relative to the values of a culture, place or time in history." In other words, either there is a morality that is internal to medicine or we end up

with full-blown relativism. Indeed, Pellegrino (1999, p. 59) notes that on the social construction view, goals can stand for "whatever political, economic, physician, citizen, or other groups determine them to be" and are thus "simply the uses to which medical knowledge or physicians can be put." Pellegrino was worried about the *corruption* of medicine: medical knowledge and skills might be used to further whatever ends a certain society deems appropriate. However, this dilemma is false, since *universal* moral systems, such as Kantianism or utilitarianism, may underpin societal norms. Thus, rather than subordinating the ends and norms of medicine to specific political or economic agendas, universal morality can have normative authority over them in one of two ways: (a) it can do so directly; (b) it can do so indirectly through *correct* and *justified* societal norms, whose correctness and normative authority would be derived, in turn, from universal morality. The ends and norms of medicine would come from outside of medicine, not in the descriptive sense that a certain society has simply decided that these are medicine's ends and norms, but in the normative sense that these ends and norms are in fact justified because they are derived from justified principles.[5] Therefore, the real alternative to Pellegrino's internalist position is not outright relativism, but rather an externalist position according to which the morality of medicine is derived from more general justified principles.

Internalists sometimes argue that if medicine's values are derived from sources external to medicine, physicians' *identity* as medical craftsmen will be compromised, which, in turn, will lead to a compromise in their *integrity*.[6] One way to motivate this worry is through a slippery

[5] Versions of this position are defended by both Beauchamp (2001) and Veatch (2000 & 2001). However, Veatch does sometimes slide into talking about mere societal and cultural norms. For example, Veatch (2001, pp. 632, 636, & 639) argues that knowing what constitutes the ends and norms of medicine "requires turning outside of medicine to the basic religious, philosophical, and cultural norms," as well as to "broader societal norms," which provide "the ends of life and the moral norms that structure that life" needed for deriving medicine's ends and norms.

[6] Indeed, internalists such as Miller and Brody (2001, p. 582) argue that "the professional integrity of physicians is constituted by loyalty and adherence to the IMM [the internal morality of medicine]." See also Miller & Brody (1995), Brody & Miller (1998), and Miller, Brody, & Chung (2000).

slope argument that builds on Pellegrino's original worry: if physicians do not have the resources to justify why there are things that they can and cannot do *qua physicians*, they will ultimately be pressured to do whatever patients or society deem appropriate and will thus become mere technicians. However, even if such a slippery slope can be avoided, there is a second, more sophisticated way of motivating the worry about the loss of physician identity and integrity: Even if a physician can appeal to *justified* external norms, rather than merely doing whatever patients or society tell him to do, the physician *qua physician* is still only providing medical knowledge and skills, while the values he advocates are external to medicine. Since there is no intrinsic connection between these external values and physicians' knowledge and skills, there is still a risk that physicians will become technicians in the sense that they merely have the relevant knowledge and skills and are thus to give patients or society whatever they want if it is consistent with values external to medicine. Physicians would thus not have the resources to justify why there are things that they can and cannot do *qua physicians*. Consider our initial example: even if a moral system were to show that amputating a healthy limb is morally permissible, many physicians might argue that this is not what physicians ought to be doing *qua physicians*. Consider another example. Robert Veatch (2001, pp. 634-635) argues that the question of whether or not physicians should participate in executions of criminals is to be settled by resolving the more fundamental normative question of the permissibility of capital punishment: if society is justified in executing its criminals, then it may construct the role of the physician so that some physicians can participate in executions. However, even if society is justified in executing criminals, it does not follow that *medical* professionals can participate in executions. Rather, society might need to authorize agents who are part of the penal system, but who are not part of the medical profession, to conduct the killings. These agents would not be medical

professionals since they would not be furthering medicine's end and thus would not be engaged in the craft of medicine.

If medicine had an end that was definitive of the practice and norms that were internal to it, physicians would have the resources to justify why there are things that they can and cannot do *qua physicians*. Their identity and integrity would thus not be compromised. However, the externalists can raise several objections to the idea that there is a morality internal to medicine. First, there is a *conceptual* challenge: it is not clear that there is in fact an end that is definitive of the practice of medicine. In particular, there are many different medical roles—physician, nurse, pharmacist—and each has somewhat different ends. Moreover, even within one single medical role, multiple and conflicting ends might be pursued. For example, an oncologist might want to prolong life, but at the same time he might also want to relieve suffering (Veatch 2001, pp. 628-632). Second, there is an *epistemological* challenge: even if it is the case that the end and norms of medicine can only be specified in terms of the practice of medicine (a conceptual point), it does not follow that medicine's end and norms can only be identified by those with experience in the practice, namely, medical professionals (an epistemological point). Perhaps distance from the practice or expertise in conceptual analysis gives one a better understanding of the end and norms of the practice than experience in the practice (Veatch 2000, pp. 78-79 & 2001, p. 624).[7] Third, there is an *explanatory* challenge: physician obligations could potentially be explained by general normative theories, such as Kantianism or utilitarianism, rather than by an internal morality of medicine. Indeed, even if there are *special* obligations of physicians, they might be derived from a vision of the good society combined with the characteristic features of medicine.

[7] Veatch bases this distinction on MacIntyre's (2007, pp. 188-189) two reasons for Xs counting as internal goods: (a) "we can only specify them in terms of chess or some other game of that specific kind and by means of examples from such games"; (b) "they can only be identified and recognized by the experience of participating in the practice in question. Those who lack the relevant experience are incompetent thereby as judges of internal goods."

There is a peculiar feature of Pellegrino's position that makes answering these challenges especially difficult: Pellegrino understood the internal morality project in *realist* terms. Thus, while Kass (1985, p. 174) had already argued that health is a "natural norm," Pellegrino (2001a, p. 171; 1999, pp. 56-57) insists that his teleological account is "realist" and defines the nature of medicine as "something in the real world independent of the construction society might put upon that reality." Indeed, Pellegrino (2001b, pp. 564-565) has argued that the internal morality of medicine is not defined by physicians and is "independent of whether or not physicians accept or reject it." Rather, the normative authority of the morality of medicine arises from "an objective order of morality that transcends the self-defined goals of a profession."[8] Apart from the well-known metaphysical, epistemological, and practical problems associated with realism,[9] a mind-independent objective moral order would do little to address the conceptual, epistemological, and explanatory challenges discussed above. What I would like to suggest is that even in its altered formulation, the dilemma posed above should be rejected; that is, it is not the case that we should endorse either Pellegrino's internalist position understood in realist terms or externalism about the morality of medicine. What is needed is an account of an internal morality of medicine that can *interact with* and *incorporate* some of the relevant sources of values outside of it. This is precisely what Pellegrino's realist internalist account cannot do.

4. Beyond the Dilemmas: A Constructivist Approach

[8] Pellegrino (2001b, p. 565) is not clear about what he means by an "objective order of morality," adding: "An internal morality of medicine […] is not a morality divorced from all ethical theories. […] It is not closed to insights from other ethical methodologies [nor to] insights from literature, history, or the social and physical sciences. […] It looks, however, beyond cultural and historical contexts to what is common to the human predicament of being ill and being healed." However, the ways in which a common human predicament gives rise to an "objective order of morality" and the ways in which this objective order interacts with other methodologies are left unexplained.

[9] See, for example, Mackie (1977) and Korsgaard (1996).

The middle road I want to offer between Pellegrino's realist internal morality of medicine and the externalist alternative builds on Howard Brody and Franklin Miller's "evolutionary perspective" on the internal morality of medicine. According to this approach, the goals of medicine and its morality are not timeless, but rather evolve over time together with human history and culture. Thus, while medicine's morality depends at least in part on concepts and normative judgments that are not internal to medicine, Brody and Miller resist Veatch's conclusion that medicine's morality is entirely determined by these external conceptual and normative considerations. Rather, there is a core ethic that is internal to medicine and that develops historically in the interactions between the medical profession and society (Miller & Brody 2001). I agree with the authors that the internal morality of medicine is an evolving enterprise that interacts with sources external to it. I also agree with Brody and Miller's (1998, p. 397) observation that "the core of medical morality must be thoughtfully reevaluated and reconstructed at intervals, and the reconstruction will be carried out by those […] who are inevitably influenced by societal values as they interpret the history [of medicine]." However, the authors do not offer a systematic method by which the standards of the internal morality of medicine are determined and by which competing values can be assessed. Their work consists primarily of offering examples of their approach, applying it to physician-assisted suicide (Miller & Brody 1995), managed care (Brody & Miller 1998), and cosmetic surgery (Miller, Brody, & Chung 2000). Thus, my aim is to provide a procedure for determining medicine's internal morality and for weighing its competing values. In what follows, I provide a *constructivist* procedure that unifies input from all the relevant sources into a coherent web of justified normative judgments and that constitutes medicine's internal morality.

There is an anti-realist way of conceptualizing "Fundamental Idea." First, an end can serve as the basis of normative judgments because it sets a standard of correctness for whatever may promote this end successfully. Second, certain ends are constitutive in the sense that the practice would not exist without them. Indeed, Pellegrino (1999, p. 59) aspires to capture precisely this idea: "Ends serve to define medicine. Without certain ends, the activity in question does not qualify as medicine." Moreover, the constitutive end of a practice is the basis of *all* normative judgments within the practice. Consider a game of chess. Winning by checkmating one's opponent is the game's constitutive end. Thus, if one is not pursuing this end at all, one is not engaged in the activity of playing a game of chess, since the activity in question would not qualify as a game of chess. Moreover, any action performed in the game of chess that is part of the game, such as sacrificing a pawn, ought to be done in light of this end. In other words, the constitutive end of the game makes normative claims on the players, who will be motivated by these claims on pain of not playing a game of chess at all. Moreover, chess has standards of excellence, and if one is a competent chess player, one will be acting in accordance with these standards in order to attain goods that are internal to the practice, such as certain analytical skills.[10] However, while the end, rules, and standards of chess cannot be altered randomly by people who play the game, they are not determined by something 'out there' in the world. Rather, the end and rules are partly definitive of what it is to play chess, and the standards of excellence were developed by those employing their chess-playing skills in order to attain the game's end. Thus, this is an anti-realist picture, as it does not assume that the end, rules, and standards in question are mind-independent.

[10] Some of these constitutive and internal aspects of a game of chess are discussed by Velleman (1996, pp. 713-714) and MacIntyre (2007, pp. 188-189).

Chess is an excellent example of how the idea of a constitutive end of a practice can be applied in developing norms internal to the practice without endorsing realist assumptions. But is medicine like chess? While chess has a well-defined end and well-defined rules, medicine does not. However, medicine is also an *evolving* practice in a manner in which chess is not: while the end and rules of chess have been set for all time—barring some decision in the future to alter the nature of the game—medical ethics continues to evolve as more scientific discoveries are made, social structures change, and so on. And here it is useful to return to MacIntyre's conception of a practice. In MacIntyre's account, a practice is determined in part by tradition, history, and social circumstances. In other words, it is a *social construction* in which a common good is attained and so there is no need to postulate an objective normative order. Indeed, MacIntyre (2007, pp. 193-194) states that "practices never have a goal or goals fixed for all time […] the goals themselves are transmuted by the history of the activity." So perhaps we can start with a *broad* end that is constitutive of medicine, keeping in mind that this end could potentially transmute over time. A good candidate is "benefitting patients in need of *prima facie* medical treatment and care."[11] This is not an arbitrary choice. First, the constitutive end of medicine, without which the practice would not exist, needs to make mention of the fact that this practice advances *medical* treatment and care (or, at the very least, *prima facie* medical treatment and care). Second, the constitutive end needs to mention the fact that the relevant treatment and care *benefits* its recipients because this is how physicians have understood their craft ever since the introduction of the Hippocratic Oath. It is important to note that "benefitting patients in need of *prima facie* medical treatment

[11] Brody & Miller (1998, pp. 386-387) argue that "healing" is too narrow to act as medicine's end. Instead, they suggest that medicine has multiple goals, such as "diagnosing the disease or injury," "preventing disease or injury," "curing the disease or repairing the injury," "lessening the pain […] caused by the disease or injury," and "helping the patient to die with dignity." They note that these multiple goals are unified by the fact that the physician is dedicated to "benefitting patients in need of medical treatment and care," but do not postulate this as the end of medicine.

and care" is different from "medicine" (the latter would have the unwanted result of making "medicine" the end of medicine): the end of medicine does not focus on medicine *simpliciter*, but on benefitting patients. Moreover, the focus is on "*prima facie*" medical treatment and care: what is considered "medical treatment and care" is not an unchanging fact of the matter; rather, its nature will be transmuted in the course of the history and development of medical practice.

We have thus found an end to medicine that is definitive of the practice of medicine: if an agent is not attempting to benefit a patient who is in need of *prima facie* medical treatment and care, then the agent is not engaged in the practice of medicine. Since this end is somewhat uninformative as it stands, I wish to argue that the end of medicine needs to be supplemented with a constructivist procedure; that is, the internal morality of medicine needs to be constructed. This procedure should include representatives of all the parties who have a stake in medicine's values: medical professionals, others professionals—for example, philosophers, sociologists, and lawyers, all of whom would function as society's representatives—and patients. Such diverse representation can also explain why the constructivist procedure should be trusted. First, this representation would ensure that participants in the construction have all of the relevant knowledge, such as medical knowledge and skills, knowledge of philosophical theories, sociological and legal knowledge, and knowledge of patient values. Second, given the various viewpoints that these participants have, dialogue between them would minimize biases and lead to greater impartiality. The construction itself would proceed as follows. Participants in the process would take "benefitting patients in need of *prima facie* medical treatment and care" as the end of medicine. Then, the participants, who, together, have the relevant knowledge, would jointly deliberate about the norms that would determine physicians' obligations *qua physicians* and the standards that would make physicians excel *qua physicians* in light of the end of

medicine.[12] Moreover, the constructivist procedure can be such that medical professionals, especially physicians, have a leading role in determining medicine's internal morality: their judgments can be given greater normative weight than other participants' judgments. This would retain the idea that medicine is a practice in which craftsmen have authority over their craft. Indeed, since deliberation about the employment of physician knowledge and skills is conducted in light of the end of medicine, physician knowledge and skills are not dissociated from the end of medicine, which unifies them, as well as medicine's values, into one coherent and intelligible activity. Finally, the procedure itself is non-viciously circular: as norms and standards of excellence are developed in accordance with the end of medicine, a richer understanding of the end is attained, which, in turn, leads to further specification of the relevant norms and standards.

My suggestion that the norms and standards of medicine ought to be constructed raises the question of whether the procedure is actual or hypothetical. While certain well-known constructivist approaches have opted for a hypothetical procedure,[13] there is a case to be made that an actual procedure ought to be preferred in the case of the internal morality of medicine. First, it would allow for greater determinacy of and greater epistemic access to the data going into the constructivist procedure, data such as the history of the practice of medicine, patient values and preferences, and so on. Second, it would allow for greater determinacy of and greater epistemic access to the outcomes of the constructivist procedure: we would be able to ascertain which norms and standards do in fact come out of the procedure in question. Third, it would allow for the actual inclusion of all the relevant parties, especially patients, in the process. This is important because even if one knows what the relevant parties want, they might nevertheless have justified complaints pertaining to the fact that they were not asked about their preferences

[12] This suggestion could be implemented vis-à-vis other medical professionals, for example, nurses and pharmacists.
[13] See, for example, Rawls (1980) and Scanlon (1998).

and so did not give their actual, rather than hypothetical, consent. Of course, hypothetical reasoning can sometimes be employed within this procedure. In other words, it is possible—and at times potentially even advisable—to consider what participants would choose were they in the given circumstances. However, the procedure I am suggesting is, at base, an actual one. This raises certain worries that will need to be addressed: How do we know if and when the procedure is successful? Are the actual results of the constructivist procedure necessarily correct, or is it possible for participants to converge on the wrong norms? Why should someone who is critical of medicine's professional code accept this code *even if* it was the result of my suggested constructivist procedure?

A constructivist procedure is successful if certain conditions were satisfied during the construction process; that is, if the procedure was carried out correctly: Did all of the relevant participants take part in the process? Did the participants deliberate in light of the end of medicine? Did they have all of the relevant knowledge? Was the agreement between participants unforced? The key idea is that the relevant agents deliberating under the appropriate conditions determine what is right. This hypothetical understanding of the procedure can serve as the ideal that actual discussions need to approximate in order to be normatively significant. Therefore, even if the procedure in question is an actual one, there will be instances when the relevant conditions will have been met and the norms arising out of actual interactions will be correct; however, there will also be instances when these conditions will not have been met and the participants will converge on the wrong norms. Consider the following two ways in which the constructivist procedure would rule out certain actions. First, the procedure would rule out actions that are contrary to medicine's end. For example, physician participation in capital punishment would be ruled out, since this would contradict benefitting patients in need of *prima*

facie medical treatment and care. Second, the procedure would rule out actions that do not adequately take into account relevant participants and/or relevant knowledge. For example, given the importance of patient involvement—which I discuss in detail in the next section—general paternalistic norms, which existed in medicine's past, will be ruled out by the procedure. More generally, my proposed procedure leaves sufficient room for critical reflection on the ongoing construction of the norms of medicine. Of course, some disagreement will always remain, but that is true of most practices. For example, people might disagree about whether fighting should be allowed in ice hockey, while still agreeing on ice hockey's end and its other rules. Reasonable disagreement about certain aspects of a practice's code undermines neither the end and norms of that practice nor the procedure through which those norms were attained.

But why should someone accept medicine's norms, even if it is the case that they are the result of the procedure done correctly? In order to answer this question, it is important to note that my constructivist picture is an account of an *internal* morality of medicine for two reasons. First, medicine's values are developed in light of medicine's end, namely, "benefitting patients in need of *prima facie* medical treatment and care." Second, it is a morality that is determined in part by medical professionals, physicians in particular, whose judgments can be given substantial normative weight. Thus, the constructivist procedure *constitutes* the appropriate and inappropriate in the medical realm and sets the standard of correctness for normative judgments within medical practice.[14] This means that the results of this procedure, when performed correctly, are authoritative in the sense that physicians can justify to society and to patients why

[14] My aim is not to defend constructivism as a meta-ethical view. Rather, I am defending a version of what Street (2010, p. 367) has called "restricted constructivist views in ethics." Such views "specify some *restricted* set of normative claims and say that the truth of a claim falling within that set consists in that claim's being entailed from within the practical point of view, where the practical point of view is given some *substantive* characterization." In other words, instead of accounting for the correctness of all normative claims, I am accounting for a subset of such claims (those that pertain to medicine) in terms of further normative claims, such as assumptions that are embedded in the constructivist procedure (unforced general agreement, justifying one's claims to relevant others, and so on).

there are the things they can and cannot do *qua physicians*. Indeed, not only can the results of the procedure differ from the judgments of individual physicians, those results also have normative authority over individual physicians: although normative judgments in medicine are constructed from interactions among physicians (and other participants), once these judgments are in place, they can be used to *correct* the judgments of individual physicians. So, to return to our original question, while a given agent might choose not to accept the professional norms that were developed as a result of the constructivist procedure, his defiance is not justified if it disregards (a) the end of medicine or (b) the fact that medicine's norms were constructed by the relevant agents under the appropriate conditions. In other words, the normative force of medicine's internal morality lies both in its constitutivist component (one is not engaged in medicine if one is not attempting to further medicine's end) and its constructivist component (all relevant parties and their knowledge were adequately taken into consideration in constructing medicine's norms).

5. Patient Involvement in the Constructivist Procedure

I wish to elaborate on the need for patient involvement in the construction of the internal morality of medicine, especially since the question of how to incorporate patient values into medicine has become all the more pressing given the prevalence of patient rights movements in recent decades. Some proponents of the internal morality of medicine defend the importance of patients' values and preferences without noticing the fundamental tension between an emphasis on this good and their own account of medicine's internal morality. Thus, Pellegrino, who argues that the internal morality of medicine arises out of the "clinical encounter" between physicians and patients (Pellegrino 1999, p. 63 & 2001b, pp. 563 & 566), also argues that "the good of the patient" includes both the patient's medical good, which aims at the restoration of the well-functioning of mind and body, and the patient's perception of the good, which concerns his

values and preferences (Pellegrino 2001b, p. 569).[15] Indeed, Pellegrino sometimes suggests that "the good of the patient" *is* the end of medicine (Pellegrino and Thomasma 1988, p. 118; Pellegrino 2001b, pp. 565-569). Apart from the fact that "the good of the patient" is a vague way of characterizing the end of medicine—without explicit mention of medical treatment, this characterization is true of any practice with patients or "consumers"—Pellegrino does not explain how his realist picture of the end of medicine and its internal morality can account for the alleged importance of patients' perception of the good in medical practice. Even if Pellegrino were right in claiming that an objective moral order can be informative vis-à-vis patients' medical good and its role in medicine—perhaps by appealing to natural norms—it is far from clear how such an order can show us anything about patient values and their role in medicine.[16] Moreover, given Pellegrino's realist understanding of the internal morality of medicine, it is hard to see how this morality can arise from the clinical encounter between individual physicians and individual patients at all.

Externalists about the morality of medicine use patient values and preferences as another reason to question the plausibility of a morality internal to medicine. Thus, Veatch (2001, p. 632), for example, notes that deciding between the promotion of "the health of the patient no matter what" and "the health of the patient within the constraints of patient autonomy" requires deciding questions that are more fundamental than medicine and outside of it, namely, ascertaining the normative status of the principle of autonomy. However, even some internalists

[15] Pellegrino develops this compound notion of the good of the patient throughout his work; see, for example, Pellegrino & Thomasma (1988 & 1993) and Pellegrino (1998).

[16] Pellegrino (2001b, pp. 569-571) adds two more components to the two listed above, which together constitute the good of the patient: the good for humans and the spiritual good. However, these additional components do not make things better. Indeed, when considering these four components together, it is far from clear how they are supposed to track an objective normative order *and* be internal to medicine: the patient's perception of the good is subjective (in contrast to the alleged mind-independent objectivity of medicine's morality) and the good for humans and the spiritual good are broader than the goods of medicine (in contrast to the alleged internality of medicine's morality).

take a similar position regarding patient values and preferences: Ladd (1983, p. 212) argues that issues pertaining to the "patient's choices" fall under "the external rather than the internal morality of medicine," and Miller and Brody (1995, p. 12) note that "ethical considerations of respect for patient autonomy […] lie outside […] the internal morality of medicine." Thus, even if one is an internalist about medicine's morality, one could maintain that patient values are not an integral component of the internal morality of medicine and that the standpoint from which patient values are weighed against medical values is the broader standpoint of external values. Consider the following example of shipbuilding. When a shipbuilder builds a ship, there are certain things that he, qua craftsman, gets to determine, given his skills and knowledge of the standards that are internal to his practice. Now, the consumer who ordered the ship can incorporate some of his preferences, of which he has the most intimate knowledge, into the construction of the ship, as long as these preferences do not violate the internal standards of shipbuilding (for example, the consumer can choose the ship's color). However, the consumer's preferences are not internal to the standards of shipbuilding: there are the internal standards of shipbuilding (given the practice's end of building good ships) and there are the consumer's preferences; the latter is not a component of the former. Moreover, insofar as one wishes to balance the demands of the internal standards of shipbuilding against the consumer's preferences, it might be argued that a third standpoint, different from either of these two sources of values, is required in order to make the all-things-considered judgment. This standpoint might simply be that of society or of universal values more broadly.

Thus, my claim in section 4 that patients should be part of the constructivist procedure both because they are stakeholders in the results of this procedure and because they have intimate knowledge of their values and preferences requires further defense. The defense pertains both to

the end of medicine and to the relational nature of medical practice. First, recall that I argued that the end of medicine is "benefitting patients in need of *prima facie* medical treatment and care." Since there is no *a priori* reason to limit what constitutes patient benefit, it should include both patients' medical good and their perception of the good (considered in light of the fact that patients are in need of *prima facie* medical treatment and care). While the physician might be the expert when it comes to the patient's medical good, it is the patient who has intimate knowledge of his perception of the good. Hence, patient values and preferences are an integral part of the physician-patient relationship. Second, medicine is a special type of craft in the sense that it is a *relational* enterprise: rather than being an enterprise in which the craftsman produces a product that is independent of the relationship between craftsman and consumer, medicine is an enterprise in which the relationship is a constitutive component of the craft itself. This is because it is in the context of the relationship between physician and patient that what will benefit the patient in need of *prima facie* medical treatment and care is *jointly* determined by physician and patient, who, *together*, have the knowledge needed to attain this end. However, if the relationship between physician and patient is a constitutive component of the craft, it also constitutes in part the internal morality of the craft in the following sense: the interactions between individual physicians and individual patients factor into determining the norms and the standards of excellence that govern the craft, as well as the goods that are internal to it, given the craft's end.

Now, if we combine the end of medicine, patients' authoritative knowledge, and medicine's relational nature, we get the following supplemental clause to "Fundamental Idea":

> **Supplemental Clause to Fundamental Idea** Given the fact that (a) the end of medicine is to benefit patients in need of *prima facie* medical treatment and care, (b) patients have authoritative knowledge of key aspects pertaining to this end (namely, their own perception of the good), and (c) what will benefit the patient is jointly determined by physicians and patients in the context of their relationship (which is thus

> a constitutive component of the craft of medicine), medicine's norms and standards of excellence, as well as the goods that are internal to medicine, are determined in part from within the relationship between individual physicians and individual patients. Therefore, patients have a legitimate role in determining the internal morality of medicine, and patients' values and preferences, which are inherent to the physician-patient relationship, should be incorporated into this morality.

The upshot of this supplemental clause is that patients and their values should be part of the constructivist procedure that determines the internal morality of medicine, since patients, in their relationship with physicians, have a legitimate role in determining the norms and standards of excellence of medical practice. Indeed, patient input can aid in developing, as part of the construction of medicine's internal morality, medical norms that incorporate qualified deference to patient values and preferences. Thus, instead of balancing the demands of medicine's internal standards against patients' values by appealing to a third and different standpoint—the standpoint of society or of universal values more broadly—the internal morality of medicine already takes into account both medical values *and* patients' values. In particular, this morality does not determine norms and standards of excellence that only promote patients' medical good, but it determines norms and standards of excellence that also take into account patients' perception of the good. Therefore, while I agree with Pellegrino's claim that medicine's internal morality arises out of the clinical encounter, my constructivist account does better than his realist account in explaining how this happens: the internal morality of medicine simply is constructed in part in the relationship between physicians and their patients. Moreover, and relatedly, by appealing to this relationship and its special status in constructing medicine's morality, my account explains how and why patients' values and preferences are incorporated into this morality.

6. Replies to Objections

I wish to conclude by addressing the objections discussed in section 3. First, we mentioned the conceptual challenge according to which there might be no end that is definitive of the practice of medicine, especially since there are many medical roles with somewhat different ends and multiple ends within each medical role. Not only can "benefitting patients in need of *prima facie* medical treatment and care" be definitive of the practice of medicine, it is a very broad end: it leaves open the possibility that there are several more specific ends for each of the medical roles—and even several specific ends within a single medical role—which are unified under this broad end. Thus, not only are physicians, nurses, and pharmacists benefitting patients in need of *prima facie* medical treatment and care, but both prolonging life and relieving suffering can easily fall under this more general end. Moreover, my account of the internal morality of medicine accounts for the fact that the norms and standards of medicine can be specified in great detail. Indeed, participants in the construction of medicine's morality will be able to offer *reasons* for favoring one course of action over another, given the end and historical development of medicine. Thus, when considering whether to amputate a healthy limb, the participants in the constructivist procedure might consider the ways in which this amputation does and does not benefit the patient as well as whether it falls under "*prima facie* medical treatment and care." They can also look at similar procedures and their history—such as sex-change operations—and consider relevant similarities and differences between the procedures. In other words, the question that ought to guide them is whether or not there is a case to be made that amputating a healthy limb falls under the end of "benefitting patients in need of *prima facie* medical treatment and care," given the vicissitudes that this end, as well as medicine's norms, have undergone.

Second, we mentioned the epistemological challenge according to which the end and norms of medicine need not necessarily be identified by medical professionals. The incorporation of professionals from outside of medicine as well as patients into the constructivist procedure answers this challenge: while the constructivist procedure can be such that physicians and other medical professionals have a leading role in determining the internal morality of medicine—as stated, their judgments can be given greater weight than other participants in the process—they do not get to determine medicine's morality by themselves. Thus, while medical professionals have knowledge that aids in determining medicine's norms and standards of excellence, other professionals and representatives from the patient population, who are somewhat distant from the practice and/or have other forms of knowledge, can and will aid in determining these norms and standards. Indeed, given the fact that not only medical professionals get to determine the internal morality of medicine, my approach is different from what John Arras (2001, pp. 653-656) calls "historical professionalism," namely, the position that physicians determine, through agreement, the norms of medicine in a historically evolving manner. As Arras points out, the mere fact that members of a given group have agreed upon certain norms is not sufficient to justify the norms to outsiders, especially when the behavior of the group in question impinges on the interests of those outside the group: physician agreement does not suffice to justify physician agreement. My internalist account is not one of mere physician agreement. Rather, there is agreement amongst *all* of the relevant parties (under certain appropriate conditions) and thus the norms and standards of excellence developed through the constructivist procedure can be justified both to members of society in general and to the patient population in particular.

Even if it is the case that my internalist account can satisfactorily account for the norms, goods, and standards of excellence of the medical profession, there is an explanatory challenge

that still needs to be met: physicians' *obligations* could potentially be derived from sources external to medicine. However, physicians do seem to have *special* obligations that are not easily derived from more general normative theories. For example, consider the case of a physician who treats both an HIV-positive man and his HIV-negative wife, where the man has not told his wife about his condition. General normative theories, such as Kantianism or utilitarianism, might very well dictate that the physician ought to tell the patient's wife about her husband's condition. However, we might want to make the case that a physician *qua physician* has a special obligation of confidentiality towards his patients, which overrides any obligation he might have to inform patients' partners (such as an obligation to protect the well-being of others).[17] Now, one could still argue that even if physicians do have special obligations that cannot be derived from more general normative theories, such obligations could nevertheless be derived from a vision of the good society combined with the characteristic features of medicine, rather than from a morality that is internal to medicine. However, the key question is whether the unique *relationship* between physician and patient gives rise to obligations that cannot be accounted for by this type of externalist appeal. The following considerations make it likely that this question ought to be answered in the affirmative. First, physicians have to navigate between various roles—guardian, technical expert, counselor, teacher, and friend[18]—and might thus have different obligations associated with each of these roles taken separately as well as with various combinations of them. Second, and relatedly, physicians have to navigate between situations in which their authority and knowledge (primarily about the patient's medical good) are salient and situations in which the patient's authority and knowledge (primarily about his or her perception of the good)

[17] For a defense of this type of position, see, for example, Kipnis (2006). As for the legal status of such positions, the law actually varies across different countries, states, and cities: some places, but not others, have laws that do authorize (or even obligate) HIV-positive patients' health care providers to inform known partners of these patients.
[18] Some of these roles are mentioned in Emanuel & Emanuel (1992).

are salient; physicians' obligations might thus vary as a function of the nature of the situation. It is thus unlikely that we will be able to derive the types of obligations needed to encompass all of the complexities associated with these various roles and situations solely from a vision of the good society combined with the characteristic features of medicine. Rather, it is much more likely that during the construction of the internal morality of medicine, physicians' obligations will be determined in part through a combination of physicians' understanding of the craft of medicine and negotiated demands on the part of their patients.

7. Conclusion

An internal morality of medicine respects the fact that physicians are not mere technicians. Rather, physicians' knowledge and skills should be understood in the context of promoting the constitutive end of medicine—namely, "benefitting patients in need of *prima facie* medical treatment and care"—and in relation to the norms and standards of excellence that are developed in promoting this end. However, an appeal to the constitutive end of medicine and to norms and standards that are internal to medical practice need not be a search for natural norms or a mind-independent moral order. Rather, I have argued that physicians ought to construct, together with others, the internal morality of medicine, a morality that has normative authority over the practice of medicine. I have also argued that patient values need not conflict with this account of the internal morality of medicine: qualified deference to patient values and preferences can be incorporated into an evolving conception of medicine's internal morality. Indeed, medicine is a practice in which physician and patient jointly figure out what would benefit the patient, and the practice's norms are determined in part in the interaction between individual physicians and individual patients. This paper has been programmatic in nature: it has laid out an agenda for the

manner in which the internal morality of medicine should be determined, an agenda that will hopefully be developed further in the future.

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