**Pathocentric Health Care and a Minimal Internal Morality of Medicine**

**Running Title: A Pathocentric Internal Morality of Medicine**

**Abstract**

Christopher Boorse is very skeptical of there being a *pathocentric* internal morality of medicine. Boorse argues that doctors have always engaged in activities other than healing and so no internal morality of medicine can provide objections to euthanasia, contraception, sterilization and other practices not aimed at fighting pathologies. Objections to these activities will have to come from outside of medicine. I will first argue that Boorse fails to appreciate that such widespread practices are compatible with medicine being essentially pathocentric. Then I will contend that the pathocentric essence, properly understood, doesn’t prohibit physicians from engaging in actions that are not aimed at combating pathologies, but rather supports an internal morality of medicine that allows medical providers to refuse without penalty to engage in practices that promote pathologies.

**Keywords**: Boorse, medicine’s internal morality, pathocentrism

**Introduction**

The idea of an internal morality of medicine is that some acts that aren’t immoral in themselves are still wrong for medical practitioners to undertake. They are wrong because they are contrary to the nature of medicine which is usually understood in terms of certain goals being definitive of the practice. One traditional conception is that its essence is to combat disease or pathology.[[1]](#footnote-1) Christopher Boorse understands a pathocentric emphasis of fighting disease “as an abbreviation for any of three things: (1) preventing pathological conditions, (2) reducing their severity, and (3) mitigating their bad effects.”[[2]](#footnote-2) Paradigm examples of actions that violate the pathocentric principles guiding an internal morality of medicine would involve physicians participating in torture or execution even if the external morality of society (the general non-role based morality) permits torture and executions. Other examples of actions that might be prohibited by a pathocentric internal morality of medicine include abortion, euthanasia, physician-assisted suicide, sex changes, sterilization, and some forms of contraception.[[3]](#footnote-3) An internal morality of medicine may even prohibit actions like cosmetic surgery and other enhancements for they don’t combat pathologies, even though they don’t cause them like the above list of medical interventions.

Some theorists holding pathocentric views about the nature of medicine are absolutists about the internal morality of medicine and would not permit physicians to engage in banned activities even if the external morality deemed it appropriate. [[4]](#footnote-4) There are other advocates of an internal morality of medicine that will accept on balance, all things considered, physicians doing some of the items on the above lists.[[5]](#footnote-5) They view such actions as just *prima facie* wrong for a physician. Boorse challenges the idea that medicine has historically been pathocentric. He draws upon a rich historical record of doctors devoting their skills to practices other than curing or preventing diseases. He concludes that such practices prevent a historically sensitive internal morality of medicine from proscribing practices like hastening the deaths of some patients or helping others avoid becoming pregnant by pills or sterilization. Boorse suggests that the rejection of such practices must have its source in moral ideas that originate from outside of medicine.

 I take issue with Boorse, arguing that he doesn’t recognize that these historical activities of doctors are not at odds with the medical craft being essentially pathocentric. I contend that we can construe medicine’s pathocentric essence in a way that doesn’t exclude doctors from applying their technical skills and knowledge of the body to ends other than thwarting pathologies. Acknowledging a pathocentric essence can instead serve merely to protect medical practitioners, enabling them to refrain with impunity from procedures that cause pathologies in their patients.

My account differs from the more conservative pathocentric accounts in that it doesn’t limit doctors to fighting pathologies.I highlight the distinction between acts “contrary to” medicine’s essence and those merely “not entailed by” its essence. Ending a life is contrary to the essence of medicine. Fighting pathologies is entailed by the essence of medicine. Cosmetically enhancing a life is neither contrary to the essence of medicine, nor entailed by its essence. My aim is to allow doctors to refuse to induce pathologies without suffering a penalty. I am not advocating that they be limited to fighting pathologies.

**II. Ancient Contraception and Victorian Obstetrical Anesthesia**

Boorse brings attention to the fact that whether one thinks that medicine has its origins in the ancient Greek Hippocratic School or the 19th century with the discovery of germ theory and antiseptic surgery,[[6]](#footnote-6) medical practitioners at those times didn’t restrict themselves to preventing and combating pathology. Boorse points to ancient contraception and modern obstetrical anesthesia. Fertility is not a disease that contraception prevents, and obstetric anesthesia is treatment for normal pain, not a symptom of disease.[[7]](#footnote-7)

Boorse claims two points are crucial for his argument. First, contraception on demand was not universally condemned, so we can erase it from the Western medical tradition only by expelling those ancient physicians who prescribed it. Second, even if Hippocratic medicine is canonical, as commonly maintained, it doesn’t seem to have placed restrictions on contraception. The most quoted passages in the Hippocratic corpus don’t place any limits on contraception.[[8]](#footnote-8) Nor was contraception dispensed just to prevent pathology.[[9]](#footnote-9) Advice was even given to the *hetairai*, a group of high class courtesans, so they could practice their trade without interruption.

Boorse considers the alternative possibility that scientific medicine originated in 19th century. He draws upon Wootton’s work where it is argued that not until the 19th century did “physicians” do more good than harm, that is, the result for patients became better than placebo effects. So scientific medicine, on Wootton’s approach, has a recent origin. Earlier “medicine” was no more medical than astrology was astronomy. But Boorse points out that even in the 19th century, anesthesia during labor achieved near total acceptance. While women suffer great pains in labor because of the size of the fetus’s cranium and torso, and strong contractions and widening of various areas is needed but painful, the pain is normal for delivery and not pathological. The pain is inherent in human design, either as a design flaw or perhaps encouraging women not to give birth alone or, according to psychoanalysis, to help them bond with their children.

Boorse concludes that these examples (contraception and obstetrical anesthesia) prove one of two things: either i) medicine has no essential connection to disease or ii) physicians may practice qua physician something besides medicine. Either way, physicians are not limited to promoting health. There was no Golden Age of pathocentric physicians. So Boorse concludes that no internal morality of medicine offers good reasons to ban controversial actions by doctors such as euthanasia and enhancements.

The Boorsian critique seems to be that most defenders of an internal morality of medicine wrongfully think that medical providers have wandered away from the essence of medicine that existed at medicine’s origins or during its prime. But there was never a time when medicine was so pure and thus there is no reason to think that such an internal morality of medicine is based upon medicine’s essence. So Boorse criticizes pathocentric accounts of medicine. One target is the Oxford English Dictionary that understands a physician to be “a person trained and qualified to practice medicine” and then defines medicine as “the science or practice of diagnosis, treatment and prevention as disease.” Boorse criticizes Pellegrino’s (2001, 569) conception of the internal morality of medicine as one geared towards serving a single end or intrinsic good of healing – “the return of the physiological function of mind and body” and “the relief of paint and suffering”.[[10]](#footnote-10) Boorse also laments Veatch’s identification of health and medicine (2001, 640-41) for that makes it appear that the practice of medicine is the promotion of health.[[11]](#footnote-11) And Boorse also argues against Brody and Miller’s evolutionary theory of the internal morality of medicine on the basis that “it is important to eliminate (their) limitation of medicine to ‘disease and injury’, a phrase which I shall presume amounts more or less to ‘pathological condition.’” Boorse claims that “Miller and Brody are wrong to think that traditional medicine has ever been restricted to health promotion.” Boorse concludes that there is no threat to professional integrity when physicians go beyond health-related goals. Whatever reasons there are to prohibit euthanasia, contraception or physician-assisted suicide, etc., they will have to come from an external or general morality. One can’t base such bans upon the practices or principles inherent in the nature of medicine.

**III. Pathocentric Medicine**

Boorse imagines three responses to the physician being unbound from a focus on the pathological: i) Retreat and reject as unethical all of physicians’ treatments of normal conditions;

ii) Endorse these as ethical acts by physicians, but not as medical since they’re not health directed;

iii) Accept them all as medicine embracing an internal morality of medicine that allows any use of biomedical knowledge and technology for the patient’s benefit.[[12]](#footnote-12) Option i rejects medical history. If ii or iii are accepted, then there are no objections from an internal morality of medicine against voluntary active euthanasia and enhancements because these are either genuine medicine or permissible for doctors to undertake. Thus there is no objection on the basis of an internal morality of medicine to such practices. We would be left with only objections from general or external morality.

Boorse overlooks two other responses. The one that I prefer is that there is a pathocentric essence of medicine and this provides grounds for why doctors should be able to *refuse without penalty* to participate in actions that promote pathology, as is obviously the case with suicide, abortion, executions, torture, as well as live donor organ removals and sex changes, sterilization and some contraception. A second possibility, one about which I am not as enthusiastic as the first, is that doctors should be able to refuse without penalty to engage in acts that while not contrary to medicine’s essence of fighting pathology, are not entailed by the essence. Enhancements are practices that neither promote pathologies nor combat them. Perhaps some contraception avoids being so classified as pathology promoting if it interferes in the way that condoms and diaphragms do without directing killing sperm or damaging the body as do vasectomies and medications that prevent ovulation cycles.[[13]](#footnote-13)

My contention is that Boorse fails to appreciate that there is a conceptual analysis defense of clinical medicine’s pathocentric core. It doesn’t matter that doctors have always prescribed contraception or provided relief for natural pain, or even if they always practiced cosmetic surgery. Such practices might still not be essential or central to medicine, just as it doesn’t matter if the army always helped out with disaster relief, quelling riots, and search and rescues. If the institution known as the “army” didn’t protect against foreign military threats, then we would say it was not an army even if it did search and rescues, put down domestic riots, and provided disaster relief. But if the institution called the “army” only protected against the foreign military threats, we would still say it was an army despite not helping out domestically with riots, disaster relief, or search and rescues. The essence of the army is to protect against foreign military threats. Something structurally similar can be said about medicine. If some people refused to cure the sick or ameliorate the consequences of their pathological conditions, or prevent diseases, but only prescribed contraception, alleviated natural childbirth pains, and removed unattractive wrinkles with creams, we would say they were not physicians. But if such persons only prevented disease, cured the sick, and lessened the effects of the diseased, but refused to prescribe contraception, do cosmetic surgery, or alleviate the pains of childbirth,[[14]](#footnote-14) we would still be inclined to label them physicians.

Boorse presents a clever challenge to my critique of him writing “On your view, if an anesthetist only gives anesthesia in normal deliveries, is she no longer a physician? Are surgeons who do only cosmetic surgery no longer physicians? I think you need to answer this objection somehow.”[[15]](#footnote-15)

My response to Boorse’s objection is two-fold. First, I make a more minor point. Boorse’s asking whether the individuals would be “no longer physicians” suggests that they used to combat pathologies and thus did more than the non-therapeutic procedures that now monopolize their practices. They once were clearly physicians by any standard, so my concern is that their past classification is biasing our attitudes to their present practices since we may be prone to provide classifications that characterize their entire career. Moreover, there is vagueness about the duration of the period where they must no longer practice pathology-fighting medicine to cease to be classified with the physicians who do. So it is better if we imagine them *never* having done anything but cosmetic surgery and non-therapeutic anesthesia. I suspect that we would be more inclined than before to withhold the label of physician from them. We might be more willing to treat those anesthesiologists like hospital technicians who control the climate and lighting of the operating room, making sure the lighting is soft and pleasant, the air is pure, and the temperature is comfortable for the exposed patient. And we would be more amenable to considering the well-trained persons carrying out only cosmetic procedures their entire career as high-tech beauticians.

My main response is that Boorse’s examples may mislead our classificatory efforts because the persons in questions are assumed to have the complete medical treatment skill set that would allow them to engage in the standard procedures of pathocentric medicine. Anesthesia is used for pathocentric surgery as well, and cosmetic surgeons have the skills to do therapeutic surgeries on facial injuries and other appearance affecting pathologies. It will help to offset the distortional role of their background knowledge upon our classifications if we imagine the cosmetic practitioners having only the set of skills to work on enhancing skin tone and changing in an aesthetically pleasing way the shape and appearance of noses, eye lids, etc. but lacking the know-how to do any plastic surgery combatting pathologies. We would be much more inclined to claim they weren’t medical practitioners if they not only didn’t want to treat pathologies but couldn’t do so effectively if they were so inclined.

Contrast our response to such non-pathology fighting technicians with plastic surgeons who only had the skill set to engage in pathology-curing operations and didn’t know how to tighten aging skin or create swollen (bee sting) lips and produce other cosmetic enhancements. We would not be inclined to doubt they were physicians. So there is an asymmetry in how we classify those without the abilities to do enhancements and those without the abilities to counter pathologies.

Boorse, or the reader, may protest that it is unrealistic and unfair to propose a classification of those who only want to do enhancements *and* who lack the skills to practice any pathology-combatting medicine. So let’s assume a moderate case where the skill set enabling those solely engaged in cosmetic enhancements also provides them with the skills to reshape noses and tighten skin that has been damaged due to *pathological* agents. The procedures for the enhancements would be the same as those of medical treatments. To help us here still resist any pull to include those enhancement-only providers as engaged in the practice of medicine, consider an analogy between security guards and merely cosmetic surgeons. Imagine that the security guard at the sporting goods store uses the skills he learned on the football field to tackle shoplifters with stolen footballs in their possession. He even knocks the ball out of their hands when he tackles them, just as he used to cause fumbles when tackling opponents on the gridiron. We can even imagine him next punting the ball away from the thief or passing it over his outstretched hand to a fellow employee. Just because there is a narrow description of the security guard’s abilities and movements that is the same as that given of a football player tackling an opponent is no reason to claim the security guard is a football player. He is engaged in a very different goal than a football player despite his skills arising from his earlier playing football and their still being applicable to success on the football field. The aims of providing security and playing football are very different, as are the aims of enhancement and treatment. We wouldn’t classify the practitioners of each pair as being in the same field despite their skill sets allowing them to do what the other does.

**Protected Refusals**

My approach to conceptual analysis suggests that an essence of medicine exists even if doctors never in the history of their profession limited themselves to just the essential practices.[[16]](#footnote-16) This renders Boorse’s history lessons just defeasible evidence for a non-pathocentric medicine. If there is such an essence, a bioethicist, more conservative than myself, might argue that all acts contrary to it should be banned. Or such a bioethicist might prefer the even more extreme position, that not only are acts that promote pathologies to be banned, but that those not entailed by the prevention and treatment of pathologies are also to be prohibited. The latter would include a ban on enhancements that don’t produce any pathologies and make people better than normal. I will argue in this paper for much less. My position is that once we have a core or essence, we can apply a minimal internal morality of medicine that allows medical practitioners to refuse to act *contrary* to their profession’s essence. They will be able, without penalty, to refuse acts that conflict with the pathocentric core even if the external (social) morality advocates such acts. So on my pathocentric but minimal internal morality of medicine, it doesn’t follow that physicians are restricted to actions entailed by the fight against unhealthy conditions.

Why should medical providers be allowed to avoid certain practices? Well, it is contrary to the nature of the profession that they entered. They didn’t sign up for such when they became doctors, nurses or pharmacists. They professed allegiance to the principles of a profession that was devoted to healing and making people whole. In addition, it could very well be that their vocational self-understanding and professional integrity are tied to these ends. They conceive of themselves as tasked with saving the lives of present generation *and* the preventing the destruction of those of the next. They can’t easily, and shouldn’t have to, think of themselves as both healers and killers. They mastered a healing vocation and not another profession. Even if the external morality maintains that it is moral, all things considered, to facilitate abortion, euthanasia and sterilization, etc., physicians have a right to not do so, and may even believe that they have a duty to refrain from these actions lest they compromise their professional integrity.[[17]](#footnote-17)

Let’s turn now to the main upshot of the operations of minimal internal morality of medicine - protected refusals. My conception of a minimal internal morality of medicine is that once the essence is understood, medical providers (doctors, nurses, and even pharmacists) should be allowed to refrain from carrying out certain requests of an external morality’s requests. That is, they can refuse to abort fetuses, castrate or mutilate willing patients, torture terrorists or execute prisoners, provide some forms of contraception, even emergency contraception (I’m assuming that the latter consists of abortifacients) despite the external morality of society being one that has come to want medical providers to start doing those things. And they should be protected and their conscience recognized in a way differing from say, a Jehovah Witness doctor in the Emergency Room. The latter should not be allowed in the Emergency Room if she would refuse to provide a patient with a necessary blood transfusion. She loses her job, or is prevented from having such a job for she is refusing to do what is central or essential to medicine – curing patients.[[18]](#footnote-18)

The internal morality of medicine could be construed as rendering certain actions non-mandatory. On my minimal internal morality of medicine physicians can legitimately opt out of certain acts by appealing to the nature of their profession. Prison- or army-employed physicians cannot be morally commanded to increase pathologies through, respectively, executions, or torturous interrogations. Hospital and clinic workers should be able, without penalty, to refuse to provide abortions or even contraception that makes organs malfunction.[[19]](#footnote-19) The right to refuse should also be extended to pharmacists unwilling to prescribe abortifacients, and to Catholic hospitals when governments or insurers insist that they must provide such contraception. I would extend the same protection to a doctor’s refusal to remove a vital organ from a living donor, even a redundant organ like a kidney. [[20]](#footnote-20) And medical schools training the next generation should allow students to refuse to learn how to perform an abortion, contra Allison Jaggar, who insists that ob/gyn training and certification should require abortion training and practice as a matter of respect for women’s equal rights (2009).

Of course, nearly every surgical medical procedure will kill some cells but that might not make patients unhealthy - it merely means they have an unhealthy part. For example, one dead skin cell is a part pathology but perhaps not a pathology at the macro level. On the other hand, if an unhealthy part means an unhealthy patient, I would still maintain that a pathocentric essence is compatible with creating a minor pathology to prevent a greater pathology. The pathocentric account just demands that overall, the aim is that the patient’s health be improved. I am understanding a patient to be unhealthy only if a condition including a part malfunction increases the probability of death or reproductive failure. Removing one kidney raises the *probability* that a donor will have a shorter life so I consider kidney transplantation to make the donor unhealthy even if it doesn’t shorten his actual life.

I have argued that doctors can refuse to act contrary to the pathocentric essence of medicine. This is not to say that physicians ought to refuse to do things contrary to the essence of medicine, only that they should remain protected when governments or employers want them to do things contrary to the essence of medicine – abortion, executions, torture, and the like. It is a further question if they should be allowed to refuse to do things that aren’t part of the pathocentric essence of medicine, like provide contraception, cosmetic surgery, and sleep medicine for those traveling through time zones. Although I am less concerned with defending an extension of the above internal morality of medicine, other bioethicists could construe it as extending its protection to refrain not only from those acts that promote pathologies, but also from any that don’t combat pathologies such as enhancements. Nevertheless, such an application is hardly entailed by my argument. Philosophers move too quickly from the view that the core goals of medicine exclude certain actions contrary to its essence to excluding actions not entailed by its essence. It might be fine to alleviate ‘healthy’ birth pain, prescribe contraception, perform cosmetic surgery, etc.

It may be that one can allow conscientious objection to giving contraception (condoms and diaphragms) that doesn’t involve damaging reproductive organs or altering their functions since it is not fighting pathology either. That is different from saying that no doctor should give out such contraception. The sort of conscientious objection that I am now considering is an extension of the minimal internal morality of medicine that I earlier advocated wherein doctors can refuse to act contrary to the essence of medicine.

However this allegedly second realm of morally legitimate and legally protected refusals would seem to be very problematic when the issue is say, pain relief, if the pain relief in question is not considered to be a component of treating disease.[[21]](#footnote-21) For example, one wouldn’t want a doctor to be allowed to refuse to treat the normal or natural pains of child birth. But maybe there is an account of medicine as making people whole that includes pain relief. Perhaps Pellegrino’s defense of healing as restoring wholeness can allow pain relief and suffering reduction[[22]](#footnote-22) if wholeness is not meant structurally but functionally. Debilitating pain prevents one from integrating various aspects of one’s life as it reduces one to a one-dimensional pain fleeing animal or hedonist. Suffering is even defined and developed by Velleman (1999) as something like the distress experienced when collapsing as a person. Perhaps that could be seen as counting as cognitive impairment, i.e. dysfunction, when it prevents a range of cognitive and affective activities.[[23]](#footnote-23) Still I am skeptical of the prospect for success here because the labor pain-caused cognitive inabilities resemble those of sleep, which is not a malfunction but normal process of rejuvenation. Likewise for the poor mental performance of those who are sleepy right before they fall asleep and immediate after they wake up. They are not pathological limitations of one’s thought.

**Conclusion**

Whether an appeal to restoring wholeness can handle normal pain doesn’t matter, for my preferred minimal internal morality of medicine is just the right to refuse to act in ways that cause patient pathologies. Alleviating pain when diseased-caused is a proper part of a pathocentric medicine as Boorse understood it in the earlier quote (page 2) and is certainly compatible with Wakefield’s account of disorder (pathology) as *harmful* dysfunction. It just doesn’t cover pains from natural or normal functions like childbirth. Whether doctors have a right to refrain from procedures that don’t produce pathologies and thus don’t raise the likelihood of death or reproductive failure is another matter. This further refusal isn’t entailed by a pathology-fighting medicine. It is perhaps there where the external morality’s general demand for benevolence and respect for autonomy will have more force against a physician’s refusal to do something other than fight pathology.

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1. I will basically follow Boorse’s later preference for “pathology” over “disease.” While “disease” intuitively excludes injuries, drug overdoses, frostbite, and birth defects, “pathology” does not. Boorse originally used “disease” in an expansive sense to mean any absence of health. He has since switched to “pathology” which doesn’t seem as strained as “disease” when extended to all instances of the absence of health. [↑](#footnote-ref-1)
2. I will assume that Boorse intends pain to be one of the bad effects to be mitigated. All the quotes are from Boorse’s "Goals of Medicine," which is available from the following conference web page: <http://www.buffalo.edu/content/cas/philosophy/news-events/events/_jcr_content/par/download_1/file.res/Boorse-final%20goals%20of%20medicine.pdf>. The paper just came out in the collection *Naturalism in the Philosophy of Health.* 2016. Ed. Elodie Giroux, Springer Press, 148-177. [↑](#footnote-ref-2)
3. Donating organs, tissues, and even blood produces a pathological condition. [↑](#footnote-ref-3)
4. Kass (1975); Pellegrino (2001). [↑](#footnote-ref-4)
5. Miller and Brody (2001). [↑](#footnote-ref-5)
6. Boorse relies upon Wootton (2006) for this judgment about 19th century as the origins of scientific medicine. [↑](#footnote-ref-6)
7. Other examples of non-pathology fighting medicine include the “well baby” care of the normal obstetrician or pediatrician, countering discomfort from menstrual cramps, anesthetizing drugs used by athletes, and adjustment to sleep cycle when traveling. Perhaps even the medical attention gtiven to the declining performances of the elderly is just attending to the normal processes of aging rather than pathology. [↑](#footnote-ref-7)
8. “If a woman does not want to become pregnant, give to her in a drink of water moistened (or diluted) copper ore (misy) in the amount of a vicia bean, and she will not become pregnant for a year. From *On the Nature of Women* (ch 98). There is a similar much reproduced quote in the *Diseases of Women* (I, ch. 76) [↑](#footnote-ref-8)
9. While the Hippocratic oath prohibited some abortions, scholars (Edelstein and Riddle) now believe that Hippocrates did not actually write the oath, rather it was written by a fringe Hippocratic group. Other Hippocratic writings even provided advice about how to induce abortion. [↑](#footnote-ref-9)
10. Boorse notes that since Pellegrino (2001) believes “that ‘health’ means making people whole again, it seems unclear how pain relief, which is merely blocking a sensation, is a case of it, and similarly for suffering in general.” (Boorse 2016) [↑](#footnote-ref-10)
11. Boorse does note that Veatch in other places does allow that health and medicine are not identical and that justified medical treatment might not aim at health and healing. [↑](#footnote-ref-11)
12. Boorse prefers option iii. He puts forth in the same article an internal morality of medicine with basically one principle regarding patients: that it serves their interests. There may be a failure in Boorse’s account to appreciate how patients’ autonomy and interests can collide. There also may be a failure to appreciate that doctors can disregard the patients’ interests for internal reasons, not just external ones like costs to the government. Examples could be not putting someone on an organ waiting list or not providing him with an experimental drug. [↑](#footnote-ref-12)
13. It’s a fine line that differentiates between preventing conception in ways that cause part pathologies versus those that prevent it without directly inducing pathology. But Catherine Nolan has made me a little more confident that it can be sustained for she distinguishes suppressing ovulation and vasectomies which are pathology inducing from a device that traps sperm no longer in the man’s body. The death of such sperm would be a dysfunction of the sperm but not of the man or woman. [↑](#footnote-ref-13)
14. Even if they refused to lessen the pain of natural childbirth, we would call them physicians, just callous ones. Keep in mind that Boorse includes mitigating the effects under the heading of fighting disease so I think he would allow a pathocentric medicine to include pain relief from diseases. He would just insist that obstetrical anesthesia isn’t a case of disease-caused pain. If someone insists that fighting disease doesn’t include fighting pain caused by it, then one other response is available: that the duty to relieve pain is something anyone should do and thus it is part of an external morality that applies to medical practitioners while at work. One could take the same attitude towards non-pathological obstetrical pain. [↑](#footnote-ref-14)
15. Personal correspondence. [↑](#footnote-ref-15)
16. It has been claimed that a pathocentric account of medicine like that which I am defending may not be able to include informed consent as part of the nature of medicine unlike Miller and Brody’s evolutionary account. I think this is acceptable. There were physicians before the emergence of informed consent in recent decades. It need not even be seen as part of a Brody and Miller evolving internal morality of medicine. Rather it can be viewed as just an instance of a general principle of external morality that respects consent and autonomy. Medical practitioners were slow to recognize and observe that aspect of a general morality. [↑](#footnote-ref-16)
17. A referee asked for examples in other fields. Clergy may recognize the state’s legitimate need for information gathering on parishioners who are susceptible to religious-inspired violence. Nevertheless, they should be able to resist with impunity the authorities’ entreaties to themselves be informants as incompatible with their role as confessor, spiritual guide, trusted confident, agent of God etc. Another possibility is counselors/social workers in a reform school that is committed to rehabilitating juvenile offenders. Imagine that they had taken the job before the state introduced new policies that include incapacitating or merely deterring adolescents. Such reform-minded counselors could have grounds to refrain from participating in such heavy handed practices geared towards preventing recidivism and copycats as incompable with their mission of moral cultivation and transformation. A final possible example might be science teachers who firmly believe that science can be demarcated from religious creationist views. They should be able to avoid public school board pressures to teach “creation science” in their classroom. Maybe the school is free to add it to the curriculum and compare its explanatory power with that of science but if it isn’t science then it shouldn’t be required of science instructors that they teach it in their science classes as a rival scientific explanatory scheme to evolutionary science. [↑](#footnote-ref-17)
18. Maybe this minimal internal morality of medicine could be extended to doctors and nurses who didn’t want to treat certain patients, say of the other sex. Refusing to offer such a treatment would not be tolerated. But this is trickier, since unlike the Jehovah Witness doctor they are still curing others. Maybe it is just an external morality that prohibits such discrimination. [↑](#footnote-ref-18)
19. It might be thought that permissibility of doctors’ refusals to perform tubal ligation, vasectomies, and live organ procurement are bullets to bite for my view. However, I don’t think they are lethal, painful, or debilitating bullets. Keep in mind that the current practice of the double veto in transplant ethics has been defended as not violating patient autonomy. While the patient may have a right to donate an organ, she doesn’t have a right that doctors take the organ. Transplant teams can refuse to take organs without violating the patient’s autonomy. Likewise, it may be a doctor’s right to refuse to take organs or engage in other pathology-causing practices. [↑](#footnote-ref-19)
20. So unlike Boorse, I doubt the internal morality of medicine is just to serve the patient’s interests. [↑](#footnote-ref-20)
21. Boorse (2016) adds, “In fact, since the pain of disease or injury is a wholly normal reaction to it, one might expect a true purist about medical goals to condemn nontherapeutic pain relief as not true ‘healing.’ Yet no one takes that positon.” [↑](#footnote-ref-21)
22. Pace Boorse’s 2016 claim in note 17. [↑](#footnote-ref-22)
23. A referee claimed that “the idea that pain reduces integrated function or is even a cognitive impairment doesn’t seem helpful for labor pain. When those (labor processes) occur, there isn’t anything else the woman is trying to do (or cognize) besides giving birth.” Fair enough. However, she may have to make decisions about the procedure such as whether to under a Caesarian section or some other treatment and pain can impair that decision. Extreme pain can also make her less able to participate in the delivery - follow directions and relay information etc. So in that way thought is unlike the rest of the normal and healthy bodily limitations that occur during a birth. The latter don’t impair delivery as can great pain. [↑](#footnote-ref-23)