Revista Bioética
Print version ISSN 1983-8042 On-line version ISSN 1983-8034
Rev. Bioét. vol.26 no.2 Brasília Apr./June 2018
Doi: 10.1590/1983-80422018262238

UPDATE

Edmund Pellegrino: medical morality and moral consensus theory

Ivan Dieb Miziara [1], *Carmen Silvia Molleis Galego Miziara* [2]

1. Universidade de São Paulo, Departamento de Medicina Legal, Ética Médica e Medicina Social e do Trabalho, Faculdade de Medicina, São Paulo/SP, Brasil. **2.** Faculdade de Medicina do ABC, Santo André/SP, Brasil.

Abstract

The authors present and comment on the ideas of Edmund Pellegrino, a bioethics specialist born in New Jersey, USA, regarding the existence of a morality intrinsic to medicine, related to the inherent goal of the medical art, that is, the cure of the patient, as well as the existence of a morality external to medicine, which concerns all other aspects of medical activity whose ultimate purpose is not the cure of the patient. The authors also present the comments of other ethicists, for or against the arguments presented by Pellegrino, and compare aspects of this external morality to the moral consensus theory previously developed by the authors.
Keywords: Ethics medical. Consensus. Morals. Medicine. Bioethics. Ethicists.

Resumo

Edmund Pellegrino: moralidade médica e a teoria do consenso moral

Os autores apresentam e comentam as ideias de Edmund Pellegrino, bioeticista nascido em New Jersey, Estados Unidos, acerca da existência de moralidade interna à medicina, relacionada ao fim inerente à arte médica, ou seja, a cura do paciente, assim como a moralidade externa à medicina, que diz respeito a todos os outros aspectos da atividade médica cujo propósito final não seja a cura do paciente. Apresentam também os comentários de outros eticistas, contra ou a favor dos argumentos apresentados por Pellegrino, e comparam aspectos da referida moralidade externa à teoria do consenso moral desenvolvida anteriormente pelos autores.
Palavras-chave: Ética médica. Consenso. Princípios morais. Medicina. Bioética. Eticistas.

Resumen

Edmund Pellegrino: moralidad médica y la teoría del consenso moral

Los autores presentan y comentan las ideas de Edmund Pellegrino, bioeticista nacido en New Jersey, Estados Unidos, acerca de la existencia de una moralidad interna de la medicina, relacionada con el fin inherente al arte médico, es decir, la cura del paciente, así como sobre la existencia de una moralidad externa a la medicina, que se relaciona con todos los demás aspectos de la actividad médica, cuyo propósito final no sea la cura del paciente. Presentan también los comentarios de otros eticistas, en contra o a favor de los argumentos presentados por Pellegrino, y comparan aspectos de la mencionada moralidad externa con la teoría del consenso moral desarrollada anteriormente por los autores.
Palabras clave: Ética médica. Consenso. Principios morales. Medicina. Bioética. Eticistas.

Declaram não haver conflito de interesse.

Edmund Pellegrino, a bioethicist and academic whose writings were heavily influenced by the Greek philosophers Aristotle and Plato, was always a thinker on Ethics, and especially on the ethics inherent in medical practice. Indeed, his great quest - in the course of a career dedicated to scrutinising the various levels of morality present in the relations between doctors and patients - was to lay the foundations for the existence of the hypothetical philosophy of medicine. In addition, Pellegrino was always interested in resolving moral conflicts. In his words: *Ethical discourse has been altered by Kant, Mill, Hume and Bentham, who have modified the primary focus on how a good person should act for a focus on how to resolve moral conflicts expressed in difficult moral choices.*

Moralities

In the realm of morality itself, Pellegrino used some of his studies [2,3] in a teleological construction (in the Aristotelian-Thomistic meaning) to establish that medicine possesses two forms of morality. The first one is what he called "internal morality," which derives from the ends that the physician must pursue in relation to the patient. By combining the Aristotelian concept of "good" (ie what any form of art or practical activity should pursue) with the Platonic concept that health is undeniably a good to be pursued by medical practice, the author proposed that the nature of medical activity, *its virtues and benefits are defined as ends of the medicine itself* [4].

Pellegrino maintains that the purpose of medicine - to heal - determines the virtues and obligations of the health professional (that is, the very purpose of medicine is that it determines internally the ethics that guide medical practice). He states that converting or assimilating medicine for other purposes - for example, economic - is to transform and to pervert it. Any purpose other than cure is external to medicine [4]. One could say, from an orthodox viewpoint, that this is the classical Hippocratic concept of the obligations to which physicians are subject in the exercise of their art.

Pellegrino [5] denies the general idea that a morality exclusive to medicine has been accepted for centuries only for the sake of tradition or manners or because it has been sanctioned by medical associations . He insists that any morality internal to medical practice must be faithful to the true purpose of the art - to heal - and suggests *the reconstruction of medical morality as the interaction of three facets of the doctor-patient relationship - the disease; the action of the professional; a good or bad action for a patient* [1].

According to Tom Beauchamp [6], Pellegrino thinks that the physician may have goals and purposes in medical practice that are not formally linked to the "final purpose" of the profession. However, he considers these objectives to be external, and "do not resuscitate orders", abortion, forensic psychiatric evaluations, autopsies, circumcision, and rationalisation of life support systems in Intensive Care Units could be examples of Pellegrino's thinking. In other words, as the examples given - and other analogous situations - are not always associated to healing, which is the ultimate goal of medicine, those actions would be "external" ends to medical practice.

However, Pellegrino [5] now and then seems to believe, perhaps forced by the circumstances that condition the evolution of ethical concepts, that at least one paradigm external to medicine - beneficence - is also part of the paradigms internal to the profession. For the author, modern physicians have some difficulty in relation to the principle of respect for patient autonomy, since "they erroneously interpret it as being in opposition to beneficence" [7]

Beneficence: a paradigm external or internal to medicine?

According to Beauchamp, beneficence is a paradigm external to medicine [8], while in Pellegrino's view it is an internal paradigm (emphasis ours) of medical practice, exclusively oriented towards the cure of the patient. Obviously, it is a simplification of the concept of beneficence, limiting what can be considered really beneficial to the patient - This, in Pellegrino's conception, would not include, just to mention two examples used by Beauchamp [6], medical actions such as reproduction control or euthanasia.

This simplification is the most important part of Pellegrino's ethical concept. However, as it turns out, it is also his "Achilles heel." Taking beneficence as a moral principle central to medical practice and assuming that physicians are obliged to provide the various forms of benefit to their patients, there is no other moral reason why they should be prevented from performing actions whose sole purpose is to benefit the patient. In this way, both patients and society can view reproductive control, assisted

 http://dx.doi.org/10.1590/1983-80422018262238

suicide, abortion, sterilisation, and other areas of medical practice as important benefits to patients that physicians have a duty to provide.

It should be noted that none of the above practices can fit into the Pellegrinian concept of patient healing. In addition, there are cultural and religious factors involved in these issues - what some may regard as "healing" may be for others strictly prohibited or unacceptable for religious or moral reasons. Yet again, the central question in this contradiction lies in the fact that Pellegrino sees healing as the essence of medical art. As Beauchamp states, *I do not think it is possible to specify in this model, or in any other model, where medicine ends and where non medical activities begin* [8].

This concept of "cure" based on the idea of disease, very popular among laymen and even in medical schools, does not provide precise limits for what medicine really is. Since the time of Hippocrates, who enunciated ""Cure Sometimes, Treat Often, Comfort Always", the concept is vague, which subjugates this limiting view of beneficence as cure only- especially in a plural society as we live in this age of cultural globalisation.

It is also a limiting view because it does not take into account many activities of medical practice that can bring benefits to patients as individuals and to society as a whole. As examples, we can mention the suspension of futile and harmful treatments, the execution of decisions prior to hospitaliastion (such as the right not to be resuscitated), pain and suffering relief in palliative care situations, etc [9]

Medicine as a neutral activity

Brody and Miller [10] also criticise Pellegrino's position and postulate that medicine is not a neutral activity but a rather morally activity committed to its own rules, which derive from the specific goals of the art, duties, and virtues of practitioners . In other words, they derive from *the internal morality of medicine, to which physicians must adhere*, as Beauchamp asserts. [11]

Thus, integrity, for example, is a characteristic virtue of the profession, emphasised by social interaction, which, in Brody and Miller's words [10], marks the individual expression of the doctor. In our midst, still in the twentieth century, Flaminio Fávero wisely elaborated on this matter:

The physician, within the community, must be guided by the principles of general and particular ethics as a man, (...) but, because of their profession, physicians are forced to subordinate themselves to a set of precepts shaped by the unique characteristics of their practice. These concepts are created in the light of common sense or, rather, common sense, reason and order. The precepts relate to doctor's relations with themselves, with patients, with colleagues and with society [12].

However, while acknowledging the incorporation of these virtues into medical practice, Beauchamp argues that *a morality internal to medicine may not be broad, coherent, or even morally acceptable. Tradition and professional paradigms are not guarantees of minimum moral adequacy* [11], he says. Brody and Miller [10] therefore distinguish moral norms appropriate to medicine from those dogmatic and non-systematic recommendations found in many professional codes of medical ethics.

These authors [10] argue that, in general terms, medical practice is not always well defined and can be socially controversial on many occasions. This implies that the internal morality of medicine is not broad enough to include social evolution: *even the core of medical morality must be carefully reassessed and reconstructed from time to time, and this reconstruction must be done by characters living in modern society, which are inevitably influenced by prevailing social values and the way in which history is interpreted* [13].

Moreover, this internal morality itself is often questioned on its origin. Robert Veatch [14] states the need to review old Hippocratic concepts and codes written by professional medical organisations to verify the authority of practitioners to establish legitimate moral standards for their group. To this we add our interpretation [15] that the internal morality of medicine is in fact re-evaluated and modified from time to time. However, how this reappraisal and restructuring is done depends on the "moral consensus" established by the various components of society in which physicians live and the correlation of political forces between them.

Both Brody and Miller's thesis [10] and our theory [15] of "moral consensus" (a term that could had been already seen in the work of Jonsen's work, Siegler Winslade [16]) lead to legitimation of the influence of external paradigms on medical morality.

Brody and Miller [10] argue that the internal morality of medicine must be re-evaluated or reconstructed according to the demands of modern society. The authors speculate that even the practice of physician-assisted suicide may be compatible with the internal morality of medicine, although medical

tradition emphatically condemns that practice. They say: *today's physicians (legitimately) conclude that much has changed since the time of Hippocrates ... and the reconstruction of the internal morality of medicine, under certain defined circumstances, may be permitted* [13].

Beneficence according to the perspective analysed

This is a matter that, in the final analysis, once again calls into question the certainty of the principle of beneficence as the touchstone of the internal morality of medical practice or, in simpler way, of what is believed to be beneficial to the patient. As Robert Veatch [17] says, the understanding of benefit may change according to the perspective analysed. The objective benefit, to this author, is the true benefit, regardless of who performs the act, while the subjective benefit would be variable and based on the understanding of who practices the action.

Therefore, there is a divergence of opinions on the interpretation between what will be a good act or a cause of damage. In Veatch's [17] view, subjectivity must be taken into account and a good act can be defined as *what is desired by the person who performs the act or preferred by the person performing the act* [18].

From the utilitarian point of view it is necessary to understand what is a good result. *We must do this by trying to eliminate, or at least neutralize, biases and special perspectives in deciding what a good outcome might be*. [19] One possibility, for Veatch [17], would be the consensus established by several people and not the opinion of a single physician about which would be a good result. Thus, medical consideration must be integrated with the participation of the patient and / or other parties involved in the process [14].

In general, both the theses of Brody and Miller [10] and the concepts of Veatch [14,17] and their lines of argument exclude more than support the existence of the internal morality of medicine. Indeed, these authors admit that internal paradigms of medical morality may be volatile and subjective, while some external paradigms may be, as Beauchamp asserts, *profound and essential* [20]. It is to be noted that, as Brody and Miller [10] want, the reconstruction of morality to accommodate assisted suicide should not rely on the support of the internal paradigms of medical morality.

Although a rather complex situation, the doctor's assistance to terminally ill suicide should not be judged as immoral, but understood as something that goes against what is expected of medical care. This decision should therefore be considered as a flexible alternative to the recommended care and widely discussed in all its aspects [21].

Theory of moral consensus

The view of Wanzer and collaborators [21] is very close to our theory of moral consensus, initially developed to think about issues concerning the legalisation of abortion and euthanasia in our Country. As we have stated in relation to moral consensus, the major changes in the moral aspects of medical practice (in Brazil and in the world) that occurred in the last quarter of the twentieth century were the result of pressures made by society or by major social groups present in the ethical debate. According to Wanzer et al, changes in social behaviour in relation to the patient's right to die often anticipate the attitudes of legislators and courts, as well as of health care providers [21].

Needs intrinsic to communities and therefore extrinsic to traditional medical morality, have led to changes in the norms of conduct directed at physicians (such as respect for the autonomy and dignity of people, non-use of futile means of prolonging life, consent of research subjects etc.). In other words, moral consensus developed within a particular social group, motivated by the specific needs of that community, is capable of dynamically changing the internal morality of medical practice in that society.

According to Charlotte Paul [22], the internal morality is based on the expected behaviour of the medical professional during his or her daily activities. This adequacy of professional behaviour is learned and shared with other professionals and not always in written form. On the other hand, external morality would reflect the ethos of society in general [23].

According to Beauchamp, external morality plays a key role in this dynamic: *the conclusion of this fact is not that a set of norms of internal morality developed by and for physicians is inconsequential, but only that this morality is not self-justified by its internal norms* [23]. The author complements by asking *which external paradigms, if any, explain and justify modifications in medical morality?* [23]. According to this perspective, and reinforcing Paul's [22] thesis, the influence of society on the aspect of public opinion,

 http://dx.doi.org/10.1590/1983-80422018262238

laws, religious institutions, and philosophical ethics is an unquestionable source of external morality [6]. Or even, we add, reflect issues not yet covered by consensual moral analysis, such as the above mentioned cases of abortion and euthanasia [15].

In this respect, Beauchamp [6] reinforces the idea that there is a third form of approach that incorporates elements from both of what he named "internalism" and "externalism". In this way, there is flexibility between traditional and modern moral commitments, adapted according to different cultures, people and groups. He considers that an intractable secular moral pluralism pervades the modern world, causing moral commitments to be implemented in different ways across cultures and groups (and even individual decisions).

Thus, each community or group provides medicine with external standards that can influence its universal purpose and how it will serve patients and the public. These external patterns are embodied in the internal morality of medicine in a particular culture, says Beauchamp [24]. In other words, it can be deduced that the moral standards of a given culture are gradually incorporated into the internal morality of medicine by modifying it with the evolution of thought inherent to that social corpus.

This concept, which is also very similar to our concept of moral consensus [15], was best developed by Engelhardt and Wildes [23]. In Beauchamp's [6] view, however, the ideas of these authors (as well as ours) fail to recognise that even in different cultures (such as Orthodox Judaism, Roman Catholicism or Hinduism), the objective of beneficence in medical art remains the same. Other critics have accused the same authors of elaborating a political rather than a philosophical / moral theory. This accusation, where we are also included, is in our view erroneous because the incorporation of cultural elements into the influences undergone by the external morality of medicine is an obvious conclusion of the process of assimilation and in no way diminishes its initial conception of how this "internalisation" of external standards of medical morality takes place.

We recognise, in short, that Beauchamp's first criticism (that is, that even in different cultures and social groups the ends of medicine remain quite similar) raises important questions about the true force of "external morality" over "internal morality" of medicine, and demonstrates only a certain latent contradiction in the ideas of Engelhardt and Wildes [23] and in our theory of moral consensus [15]. After all, if different sociocultural groups, in one way or another, maintain a similar view of the ends of medicine, it would be possible to conclude that perhaps these external influences are not so important, but merely punctual and specific in certain cases and situations.

On the other hand, we consider that this criticism in no way invalidates the ideas of Engelhardt and Wildes [23] or ours [15]. On the contrary, it only reinforces them, since we are not dealing only with the internal morality of medicine, but how factors that forge the external morality to the medical practice end up being incorporated to its internal morality, thus assuming the character of beneficence to the patient, or, in other words, of a good act - in view of the favourable result expected and obtained by the patient.

Expanding on that, lets's suppose that abortion or euthanasia are incorporated, in a given social group, to the external morality of medicine, and therefore to the internal morality of medical practice in that same social group. Then, in this case, these actions will immediately be seen as good acts performed for the benefit of patients.

This is a crucial point that emerges from the moral issues of our time. The implementation of medical practices abolished for a long time in social groups depends on changes in the morality outside medicine. And the changes in this external morality, and even in the concept of "beneficence," or whatever actions that benefit patients, or whatever is a good act, depends on the correlation of moral forces that are embedded within a culturally heterogeneous society in which the predominant view is influential.

Final Considerations

Thus we may be obliged, after all, to agree with Pellegrino's Aristotelian view that medicine, as an eminently practical art, carries its ends in itself, requiring from its practitioner only the essential Kantian virtue of always seeing patients as an end and never as a mean. This implies practicing medicine only for the benefit of the ones who suffer, and it is never too much to repeat, with the patient's prior consent [25]. Therefore, we conclude that the Pellegrinian viewpoint, despite several criticisms, such as those cited above, turns out to be always more dynamic than it suggested at first, and more complex than many might assume. In addition, it seems clear that there are coincident points between Engelhardt and Wildes' view, our theory of moral consensus, and what Pellegrino defines as a morality external to medicine.

Referências

1. Pellegrino ED, Thomasma DC. The Christian virtues in medical practice. Washington: Georgetown University Press; 1996. p. 8-9.
2. Pellegrino ED. The healing relationship: the architectonics of clinical medicine. In: Shelp EE, editor. The clinical encounter: the moral fabric of the patient-physician relationship. Dordrecht: Springer; 1983. p. 153-72.
3. Pellegrino ED. The philosophy of medicine reborn: a Pellegrino reader. Notre Dame, IN: University of Notre Dame Press; 2008. p. 63
4. Pellegrino ED. Op. cit. 2008. p. 66.
5. Pellegrino ED. The metamorphosis of medical ethics: a 30-year retrospective. Jama. 1993;269(9):1158-62.
6. Beauchamp TL. Internal and external standards for medical morality. J Med Philos. 2001;26(6):601-19.
7. Pellegrino ED. Op. cit. 1993. p. 1160.
8. Beauchamp TL. Op. cit. p. 603.
9. Pellegrino ED, Thomasma DC. For the patient's good: the restoration of beneficence in health care. New York: Oxford University Press; 1988. p. 7-8.
10. Brody H, Miller FG. The internal morality of medicine: explication and application to managed care. J Med Philos. 1998;23(4):384-410.
11. Beauchamp TL. Op. cit. p. 605.
12. Fávero F. Medicina legal. 9ª ed. São Paulo: Livraria Martins; 1973. p. 5.
13. Brody H, Miller FG. Op. cit. p. 397.
14. Veatch RM. Hippocratic, religious, and secular medical ethics: the points of conflict. Washington: Georgetown University Press; 2012. p. 4.
15. Miziara ID, Miziara CS. Moral consensus theory: paradigm cases of abortion and orthothanasia in Brazil. Indian J Med Ethics. 2013;10(1):58-61.
16. Jonsen A, Siegler M, Winslade W. Clinical ethics: a practical approach to ethical decisions in clinical medicine. 7ª ed. New York: McGraw Hill; 2010.
17. Veatch RM. The basics of bioethics. 3ª ed. New York: Routledge; 2012. p. 47.
18. Veatch RM. Op. cit. p. 48.
19. Jonsen A, Siegler M, Winslade W. Op. cit. p. 17.
20. Beauchamp TL. Op. cit. p. 606.
21. Wanzer SH, Federman DD, Adelstein SJ, Cassel CK, Cassem EH, Cranford RE *et al*. The physician's responsibility toward hopelessly ill patients: a second look. N Engl J Med. 1989;320(13):844-9.
22. Paul C. Internal and external morality of medicine: lessons from New Zealand. BMJ. 2000;320:499.
23. Engelhardt HT, Wildes KW. The four principles of health care ethics and post-modernity: why a libertarian interpretation is unavoidable. In: Gillon R, editor. Principles of health care ethics. London: Wiley; 1994. p. 135-48.
24. Beauchamp TL. Op. cit. p. 609.
25. Miziara ID. Ética para clínicos e cirurgiões: consentimento. Rev Assoc Med Bras. 2013;59(4):312-5.

Correspondência
Ivan Dieb Miziara – Faculdade de Medicina da Universidade de São Paulo. Av. Dr. Arnaldo, 455, Cerqueira César CEP 01246-903. São Paulo/SP, Brasil.

Ivan Dieb Miziara – Doutor – miz@uol.com.br
Carmen Silvia Molleis Galego Miziara – Doutora – carmen.miziara@hc.fm.usp.br

Participation of the authors
Both authors participated in the elaboration of the project, the study design, bibliographic survey, text elaboration and formatting.

Recebido: 5. 2.2017
Revisado: 4.10.2017
Aprovado: 18.10.2017