There is Only One Sphere of Morality

Michael Nair-Collins

Physicians participate in several kinds of activities in their professional lives. Clinical care is the core function of the physician. Medical education is overwhelmingly oriented toward this function, and no one is licensed to practice without demonstrating competence in clinical care within their respective field. But some physicians engage in other activities, including clinical and non-clinical research, population health, and market-based initiatives such as serving on boards of, or collaborating with, pharmaceutical and device manufacturers.

Doernberg and Truog (2023) argued that these different activities have different ends, which yield different normative commitments and evaluative standards for right behavior, and therefore constitute different "spheres of morality" within medicine. Conflicts and uncertainties arise when physicians misappropriate the norms of one sphere into those of another. These ethical concerns can often be assuaged if physicians appreciate that different norms and evaluative standards apply to different activities, and orient their practice in accordance with the correct norms for each activity.

Doernberg and Truog begin the paper with a brief discussion of the norms they think are appropriately related to their five spheres, followed by discussion of several cases intended to show that a *prima facie* conflict arises from failing to apply the correct moral principles as appropriate to that specific activity, and that the conflict can be resolved by application of their analytic methodology.

Beginning with the practice of clinical care, Doernberg and Truog offer a surprisingly paternalistic notion of this practice (Doernberg and Truog 2023). Patient consent is not even mentioned, and there is a heavy emphasis on the Hippocratic tradition and the physician's duty to act with a primary emphasis on patient welfare (as judged, apparently, by the physician). This faulty description of ethical principles governing clinical care yields the purported conflict in the clinical research case study.

In the case, a physician finds herself considering whether it is ethical to enroll her patient in a trial, given that any clinical trial is designed to gather information for the benefit of future patients, and not primarily to benefit those in the trial. It involves randomization, rigid protocols not conducive to individualized management, and additional procedures or tests that are different from ordinary care. Doernberg and Truog claim that the ethics of clinical care cannot be squared with such practices, since there is a fundamental conflict between the commitment to act in the patient's best interests above all else, and the scientific commitment to acquire generalizable knowledge.

This analysis is rooted in a simple mistake. Those in the helping professions have no authority to help without consent; and those involved in research have no authority to enroll participants without consent. It is the same principle applied to both situations. Furthermore, they claimed that consent to participate in clinical research grants permission to elevate scientific considerations over patient's best interests (Doernberg and Truog 2023). This is an oversimplification of what a person's interests are and more importantly, who determines them. The individual who chooses to participate in clinical research or not is fully capable of determining their own best interests, and is entitled to do so. If they are not capable, then a surrogate (e.g., a parent) plays this role; in either case, the participant or surrogate is entitled to

determine what course of action is in that person's interests. If they participate in the study, they have determined that doing so is in their best interest. The researcher is not "elevating" scientific considerations over patient interests, the patient has determined that study participation *is* in their best interests, which surely include factors beyond immediate medical treatment options, such as one's desire to help others, to participate in advancing knowledge, and so on.

The purported conflict is resolved with clear and unambiguous communication that the goals of research are different, that research protocols differ from ordinary are, and so on. If the patient consents, then enroll them. If they don't then don't. This is not complicated.

The therapeutic misconception is a practical problem for obtaining valid consent, but it poses no conceptual problem. If the patient suffers from this misconception, it is the fault of whoever enrolled them for failing to educate and disclose important information, and the consent is thereby invalid. Doernberg and Truog mention consent at the end of their discussion, but fail to appreciate that it obviates prior considerations, as it reveals that there is no conflict: the same fundamental principle governs behavior in both circumstances.

The discussion of the ethics of the market was disappointing to read. Doernberg and Truog noted that "strategic secrets, subliminal persuasion, selective use of data, proprietary practices, and a wide variety of marketing strategies are widely accepted as necessary for the free and fair exchanges of the market", and that a free market, in turn, "promotes the … goal of advancing societal health" (Doernberg and Truog 2023, p. 12). The exact opposite is true. Global capitalism is among the greatest detriments to human health, indeed to habitability of the entire planet. Most of the significantly harmful social and environmental determinants of health can be tied to ideologies of profit-maximization, exploitation, and accumulation of extraordinary wealth by a small number of individuals; that is, to capitalism and its market ideology. Furthermore, the

kinds of practices noted above are paradigmatically manipulative and dishonest. It would be unethical for physicians to participate in such practices because it is unethical for anyone to participate in such practices.

The case they present involves an academic researcher who struggles with whether to accept a large grant from a for-profit manufacturer. Acceptance of the grant includes collaborating with the company in studies designed to market margarine as having health benefits. The agreement is that industry scientists will control the study design and data analysis, but the researcher will be allowed to re-analyze the data. The conflict arises because the researcher is applying norms of scientific knowledge, but the ethics of the market are different, focused on profit. Doernberg and Truog argued that, by understanding that these are different spheres, the researcher should be able to isolate the scientific from the market sphere, and make agreements that allow him to do so, while recognizing that the market-based ethics of profit-maximization is also ethical within its own sphere.

As above, there is no conflict. The physician-researcher should not accept the money. He should not participate in a situation where a for-profit company has control over study design and data analysis. More broadly, he should refuse to participate in an arrangement where the goal is not to advance knowledge but to, at least superficially, justify specific health-related claims for the purpose of selling a product on the basis of those claims. That is not science, nor is it ethical.

Doernberg and Truog mention that, “unfortunately, some partnerships produce research that is later found to be skewed” (Doernberg and Truog 2023, p. 13). Of course it is skewed. Industry funding influences the practice of research and its outcomes. And why wouldn’t it? When the goal is to find what we want to find, and there is a tremendous financial incentive to do

so, then more often than not we find it. This isn't merely a matter of lack of scientific integrity. Pharmaceutical and related industries harm millions of people, through deceptive and misleading advertising, and by influencing physicians to prescribe drugs inappropriately or that are dangerous or inefficacious. One would think that physicians in particular would find these practices odious, and not on an "equivalent moral plane" to clinical care (Doernberg and Truog 2023, p. 11). Physicians are the key target of industry manipulation, since they are the prescribing "gatekeepers" to the sale of pharmaceutical products, and they hurt their patients through prescribing unsafe or inefficacious drugs based on having been manipulated.

In any case, there is no conflict because no one should participate in arrangements like these, therefore physicians should not participate in arrangements like these. Perhaps a market ideology is acceptable in some domains, but it certainly is not acceptable when it comes to medicine. Its deleterious effects on health, within medicine and related clinical fields, and more broadly through global environmental destruction, have been documented beyond dispute: and these problems are a direct consequence of a "market morality" where profit-maximization over all other considerations is considered acceptable, even laudable.

Similar considerations apply to the other spheres. There are important moral concerns involved, but their resolution does not involve isolating practices and applying different ethical principles to different activities.

Each of the ethical principles mentioned above are fully general, not specific to physicians or any other group. We generally can't touch each other without consent, even if we would like to help. We should not disrespect each other through manipulation or through false or misleading information. We should have integrity in our work, whatever it might be. The five

spheres of medical morality posited by Doernberg and Truog are not five spheres but one; and the medical sphere of morality is just *morality*.

References

Doernberg, S., & Truog, R. (2023). Spheres of morality: The ethical codes of the medical profession. *American Journal of Bioethics*.