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Disentangling Normativity and Ethics

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Why should we obey the rules that constitute a code of conduct? If a rule is justified by conclusive moral reasons, then those reasons are sufficient, from a rational point of view (rather than, say, a psychological one), to do as the rule says we ought to do (Parfit 2011; Raz 1999). That would seem to make the rule superfluous in such cases, for the conduct that it requires is already rationally required by conclusive moral reasons. But, if that rule is not so justified, then doing as the rule says we ought to do is morally problematic.

This jurisprudential puzzle about the obligation to obey authoritative rules is implicated but overlooked in Samuel Doernberg and Robert Truog's essay on the conflicting moral spheres, or ethical codes, of the medical profession (Doernberg and Truog 2023). In what follows, we assess that implication and suggest two ways in which it might alter their story about the spheres of morality in medicine. Specifically, we argue that:

1. the conflicts of these spheres are structurally similar to conflicts between rule-based systems, such as law, and morality; and,
2. resolving these conflicts is confounded by the view that the spheres in question are morally obligatory rather than normative (with moral implications).

What these two arguments share is a focus on the distinction between what is moral and what is normative. The two do not, as we shall argue, always coincide. Conflicts between what Doernberg and Truog call "spheres of morality" are more aptly understood as conflicts between morality proper and spheres of normativity. Confounding the two, on the other hand, makes it seem as though we have a problem between rival systems of morality when, in fact, we do not.

REASONS

You ought to do what you have most reason to do.[1] That is a fairly standard view in the theory of reasons today (Raz 2011). But what do you have most reason to do when reasons conflict?

Doernberg and Truog claim that the medical profession contains five "spheres of morality"—clinical care, clinical research, scientific knowledge, population health, and the market—that frequently throw up conflicting reasons for action, and which can pose challenges for determining what one ought to do from an ethical point of view. These conflicts arise despite the fact that each sphere must be consistent with, and accountable to, "morality writ large" (Doernberg and Truog 2023, 9). In considering conflicts in the conduct of clinical research in particular, Doernberg and Truog note that:

> placebo-controlled trials of antidepressants are vital for evaluating the efficacy of new treatments, even though an ethical physician could never justify prescribing a placebo to a patient outside the context of the trial (Doernberg and Truog 2023, 12).

Or, in the context of conflicts that arise as a result of industry-funded research, they observe that,

> [w]hereas the norms of science encourage the quest for truth and require objectivity in all those who pursue it, the commercial code of ethics relies on persuasion in marketing and the subordination of truth to the commercial enterprise (Doernberg and Truog 2023, 14).

In order to successfully manage "the tension between the ethics of the market and the norms of

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[1]For a critique of this view, see Bittner (2003).

science," Doernberg and Truog claim that we "should recognize that both sides have different goals and should be allowed to maintain their own standards and ethical norms" (ibid.). We do not doubt that the market has norms. But are these norms of morality or are they of a normative system with potential moral implications? To capture the distinction, consider chess.[2] In a game where your chances of a win are hopeless, you ought to play for a draw, for that would be a better result than a loss according to the rules. But it is not a moral reason for action, barring truly extraordinary circumstances (e.g., your opponent's life hangs in the balance). How so?

Moral reasons typically obligate action,[3] i.e., rationally, you must do as they require (but "typically" because sometimes they just make certain actions permissible).[4] Yet when normative systems, such as law, contain rules that obligate you to act in some way, it is because those rules paraphrase reasons for action that already apply to you—regardless of what you think—as a result of being part of morality proper.[5] The reasons for action we find in chess, however, do not obligate unless you decide to play the game. *If* you play, then there is a discrete set of rules that determine what you can and cannot do. Those reasons are normative because they direct action. But their normativity depends on whether you fancy a game.

Some of the "spheres of morality" that Doernberg and Truog have in mind are, in this light, more like chess than morality insofar as their rules are opted into rather than obligatory *tout court*, i.e., regardless of your wishes. To take the examples noted earlier, medical professionals are not morally obligated to opt into funding arrangements with corporations in which "the structure of the activity itself" risks the "gradual erosion of scientific norms" (Doernberg and Truog 2023, 14). Nor are they morally obligated to opt into enrolling their patients in research in which they risk receiving care that would be inferior to other treatment options. To suggest that medical professionals are morally obligated to accommodate the commercial interests of funders *and* morally obligated to retain control of the data that comes out of their funded research is the only way you get to the conclusion that there is a conflict between these "moral spheres" for medical professionals. But there isn't such a moral conflict, at least not without an argument for why medical professionals, by dint of being medical professionals, are subject to these obligations in the first place and at the same time. Without such an argument, we ought to avoid the false pressure that comes of the language of moral obligation, which makes it seem as though certain conditions constitute the natural default or are necessarily built into what it is to be a medical professional. Indeed, some might say that part of what it is to be a medical professional today is to reject the suggestion that some normative systems, such as "the market," ought to be accommodated at all.

Now you might think that the moral obligations in question stem from contractual promises that doctors opt into. That may end up being a fine view. But it will depend on the details of the promises. To take a preceding example, doctors are not obligated, by virtue of being doctors, to involve themselves and their patients in clinical research. They can just provide treatment that is focussed on the interests of the patients before them. But if they do enroll their patients in a trial, they have opted into the normative system, or the code of conduct, that regulates the research. That system will have rules that constitute reasons for action and, even if those rules are not all things considered moral reasons, they might be conditional moral reasons (e.g., if you do x, you ought to do y, though not doing x is morally permissible). However, and as we say, whether or not those rules constitute moral reasons is contingent on the details of those rules; obviously, if the rules require that you do something morally impermissible, they cannot be moral reasons for action, though they may retain their status as reasons for action from the point of view of the code of conduct to which they belong (and that point of view may well be wrong). If that code stipulates that the rules it contains must comply with "morality writ large," as Doernberg and Truog put it, *even then* the rules will not constitute a moral sphere that obligates in the way that morality obligates. The latter obligates regardless of your wishes; the former require that you first opt into their normative system before any duties become relevant. But doctors need not opt into all of the spheres Doernberg and Truog have in mind and, so, need not resolve their conflicts.

None of this is to say that the rules or norms of, say, clinical research or population health cannot be rationally binding. The brief explanation for how this is possible, as suggested earlier, is that such rules or norms can be so binding insofar as they require that you act in ways for which you already have reasons—frequently, moral reasons.[6]

[2]For related discussion, see also Marmor (2006).

[3]On why moral reasons obligate, see Darwall (2017).

[4]For complications and related literature, see Smith (1994) and Gewirth (1978).

[5]For extended discussion of this paraphrastic view of rules, see Hass (2021) and, relatedly, Hass (2023). For background, see Rawls (1955), Lyons (1965), and Hodgson (1967).

[6]For extended discussion, see Hass (2021) and also Enoch (2011). For a competing view, see Raz (2011).

CONFLICTS

The foregoing considerations take us to our second and final point. In pitching the story as one in which distinct moral spheres are in conflict, Doernberg and Truog raise the bar on what we need for resolution. For to resolve a conflict between morality and another normative system—even one as serious as the law, never-mind the market—is a no-brainer: *ceteris paribus*, you ought to do as morality requires of you.[7] But if the conflict is cast as though it is between the incommensurate values of rival moral systems (Broome 2000), then many of one's problems are likely to be extremely complex and intractable.

These observations reveal that there is also a pragmatic upside to rejecting the idea that there are as many moral systems as Doernberg and Truog claim. The fewer the number of such systems, the less medical professionals (or anyone, for that matter) will be subject to the serious matter of competing moral obligations. Instead, we suggest that a more helpful and straightforward view retains morality proper on one side, followed by the normative, rather than moral, systems—such as clinical care, population health, etc.—to which medical professionals are subject on the other. This minor adjustment in Doernberg and Truog's framework, as we say, has the benefit of not burdening medicine with moral claims from normative systems which we may not want to include in our conception of what it is to be a medical professional. There is, in other words, more choice in the matter of the obligations we want for the profession.

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[7]See also Raz (1996, 341).

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