

# Philosophy *of* Medicine

Letter

## Integrating Normative Philosophy of Medicine in Interdisciplinary Research: A Problem

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Philosophers of medicine are increasingly invited to take part in large interdisciplinary research projects. We are usually told that our normative expertise is needed, and that this is a good thing. I write from my own experience in such projects, with a growing sense that while the invitation is often sincere, the conditions under which philosophical work is expected to function are rarely made explicit. As a result, a certain tension tends to emerge—one that does not reject philosophy outright but quietly makes it harder to do what it is supposed to do.

Normative philosophy of medicine, at least as I understand and practice it, is not mainly a descriptive activity. It is not about mapping attitudes or predicting behavior. Its task is to make explicit the normative assumptions embedded in medical practices, to clarify concepts such as autonomy, uncertainty, benefit, and harm, and to ask whether the way things are done is actually justified. The relevant standards here are argumentative coherence and justification, not feasibility or acceptability.

In interdisciplinary research settings, however, this kind of work often takes place in environments that value stability, procedural continuity, and risk management. In my experience, philosophical analysis is welcomed as long as it remains broadly compatible with existing practices. Difficulties arise when it starts to show that those practices are normatively contingent—that they could have been organized differently, justified differently, or perhaps not justified at all. At that point, philosophy tends to become slightly uncomfortable company.

This discomfort does not usually stem from a lack of understanding—quite the opposite. Philosophical arguments are often understood very well. What tends to trigger resistance is what happens next. When normative analysis points toward conclusions that are normatively demanding or institutionally inconvenient, a familiar response emerges: This cannot be settled by conceptual reasoning alone; we need data about what clinicians think, or about what patients would prefer.



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A concrete example may help. In one interdisciplinary project I have been involved in, a normative question arose concerning the disclosure of incidental findings in a clinical monitoring context. The philosophical contribution consisted in analyzing the concepts at stake—autonomy, the right not to know, professional responsibility—and in developing arguments about what could count as ethically justifiable disclosure practices. The response was not that these arguments were unclear or mistaken. Rather, it was suggested that such conclusions were of limited value unless they were supported by empirical evidence about clinicians' attitudes or patients' preferences.

Requests of this kind are, of course, entirely legitimate in many contexts. But here they also signal a shift in the terms of the discussion. A normative question—*what ought to be done, and why*—is quietly transformed into a descriptive one—*what relevant stakeholders currently think*. At that point, philosophical analysis is not rejected but displaced. It is treated as a preliminary step that must be validated, or even replaced, by empirical inquiry before it can be taken seriously.

This is a category mistake. Normative philosophy of medicine does not claim authority by appealing to opinions but by offering reasons. Its role is not to predict acceptance or measure consensus but to clarify which options are ethically defensible, even when they are contested, uncomfortable, or unpopular. When philosophical work is required to defer systematically to stakeholder views in order to count as relevant, its critical function is effectively neutralized.

This issue is not confined to bioethics in a narrow sense. It concerns normative philosophy of medicine more broadly, including conceptual work on diagnostic categories, reflection on medical uncertainty, and discussion of the aims of medical practice. When interdisciplinary projects lack a clear understanding of what normative philosophical work is—and what it is not—philosophers risk being included only on the condition that their conclusions remain reassuring.

This recurring displacement of normative questions into empirical ones raises a further issue that I would like to put to the philosophy of medicine community. Is this pattern a by-product of the increasing tendency of contemporary bioethics to frame normative problems primarily in empirical terms—through qualitative research, stakeholder engagement, and preference elicitation? And if so, is this a path that philosophy of medicine should simply follow?

I do not raise these questions to deny the value of empirical bioethics or qualitative research, which clearly have an important role to play. Rather, my concern is that when empirical inquiry becomes the default response to normative disagreement, the distinctive contribution of philosophical analysis risks being obscured. I offer these reflections in the hope of opening a discussion about how normative philosophy of medicine should position itself in relation to the empirical turn, and about what may be lost if conceptual and argumentative work is treated as insufficient unless it is supplemented—or validated—by data.

### **Disclosure Statement**

No competing interest was reported by the author.