Commentary: Beyond Common or Uncommon Morality

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In "Medical Ethics: Common or Uncommon Morality,"[1] Rosamond Rhodes defends a specialist view of medical ethics, specifically the ethics of physicians. Rhodes's account is specifically about the ethics of medical professionals, rooted in what these professionals do. It would seem to follow that other healthcare professions might be subject to ethical standards that differ from those applicable to physicians, rooted in what these other professions do, but I leave this point aside for purposes of this commentary. Rhodes's view includes both a negative and a positive thesis. The negative thesis is that precepts in medical ethics—understood as the ethics of physicians—cannot be derived from principles of common morality. The positive thesis is two-fold: that precepts in medical ethics must be derived from an account of the special nature of what physicians do, and that this account is to be understood through an overlapping consensus of rational and reasonable medical professionals. While I agree emphatically with, and have learned a great deal from, Rhodes's defense of the negative thesis, I disagree with both claims in Rhodes's positive thesis, for reasons I will now explain after a brief observation about the negative thesis.

Rhodes's negative thesis will surely also be criticized on many grounds, including that she unfairly characterizes what she takes to be the widely accepted view in medical ethics, and that her account of 'common morality' conflates views in moral philosophy with moral views that are widely held among a population. At a minimum, however, Rhodes presents a fair challenge to the field of bioethics: that it has been too readily shaped by a set of classic views in moral philosophy rather than an account of what physicians do and the circumstances in which they act.

Rhodes makes the fair point that one counterexample suffices to show that an account of the ethics of physicians cannot be derived from common morality. In the interest of space, I will focus on one example that I take to be a counterexample to both aspects of her positive thesis—confidentiality and patients with serious contagious diseases such as HIV.

As I understand her, Rhodes would develop an account of whether and how confidentiality should (or should not) be protected in these circumstances from the special skills and responsibilities of physicians. The justification for the exercise of these special skills and responsibilities depends on warranted trust. (Parenthetically, although Rhodes does not give an account of trust, it would surely seem that she must be assuming an account of trust on which it is warranted, such as that of Annette Baier.)[2] Two basic principles are critical to this trust: (1) the obligation of physicians to seek trust and be deserving of it; and (2) the fiduciary obligation of physicians to use their skills only for the benefit of patients and society. The specifics of what (1) and (2) require, Rhodes then says, depend on professional expertise: "Medical professionals are the ones who define professional duties because they are the only ones who adequately understand what is involved." [3]

Cambridge Quarterly of Healthcare Ethics (2020), **29**, 426–428.

doi:10.1017/S096318012000016X

The trouble starts but does not end with (2). Suppose we ask what the fiduciary obligations of physicians are, to both patients and society, when patients have serious contagious diseases. There is an anodyne answer to this question: physicians should protect society while at the same time not taking action that undermines patient trust. This answer is anodyne for many reasons, including that it does not provide guidance about what it means to protect society, what actions will justifiably undermine patient trust, or how patient trust is to be balanced against social protection if there are conflicts. Discussions in bioethics have sometimes punted to the law on this problem, concluding that physicians should discharge their ethical obligations by informing patients that they will be legally obligated to disclose information such as positive HIV test results. This answer, however, does not address whether there might be circumstances in which physicians have ethical obligations to disobey the law, or whether as a matter of professional ethics physicians should actively be trying to change the law.[4]

To provide ethical guidance to physicians, more is needed than these generalizations that are effectively meaningless. Some special knowledge on the part of physicians is surely relevant. For example, we might need to know the seriousness of the disease, its mode of transmission, and forms of treatment and prevention. With HIV, for example, expert knowledge about the significance of viral loads for transmission risks and the efficacy of treatment as prevention are critical.[5] But other information is relevant as well, such as epidemiological knowledge about subgroup risk, sexual practices, and access to care.[6,7] Social judgments are relevant, too, such as attitudes toward risk; societies may vary in the extent to which they tolerate risk or in the grounds on which they find risks acceptable. Other social judgments will be highly controversial and subject to moral criticism, for example judgments condemning promiscuity, extra-marital sex, or same sex relationships, and thereby devaluing confidentiality protections in favor of more punitive approaches.[8] Medical ethics will need to recognize the existence of these attitudes, even if only to criticize them. My point here is not to defend any particular set of answers about confidentiality protection but only to argue that answers cannot and should not rely solely on the expertise of medical professionals.

Perhaps the problem lies with Rhodes's inclusion of social benefit in (2). Physicians' special skills and responsibilities do not lie in providing social benefit, but in treating patients. So (2) might be reformulated to consider only the fiduciary obligation of physicians to use their skills for the benefit of patients and thereby seek and be deserving of trust as in (1). Here, too, confidentiality in the case of serious contagious disease is a counterexample. Medical professionals have special knowledge about the medical course of disease, treatment alternatives, and their risks and benefits, special knowledge that is surely part of what will be for the benefit of patients. But judgments about what will be medically beneficial are only part of the story about what will be to the patient's overall benefit. For example, patients in subgroups in which HIV outbreaks are occurring could be benefited by more frequent and targeted testing and data sharing than patients in subgroups in which infections have not occurred.[9,10] Subgroup experiences may also be relevant. For example, HIV conspiracy beliefs persist among over one-third of US African-Americans especially in lower income levels, suggesting that disclosure of test results in this population could be especially problematic for trust.[11]

Physicians do have special skills, responsibilities, and knowledge. Simplistic invocation of claims to autonomy, beneficence, nonmaleficence, and justice fails

to take the special nature of professional practice into account. Nonetheless, a consensus of medical professionals is insufficient to provide adequate guidance for difficult ethical issues such as confidentiality in the face of serious contagious disease. Much more is needed, including patient experiences and values, and the critical features of social contexts in which decisions are to be made. Answers about how to further warranted patient trust and respect fiduciary obligations to patients will not be the same for all contexts. Rhodes's positive thesis is an idealized and medicalized abstraction. Her negative thesis, however, is a critical corrective to views in bioethics that themselves abstract from the special skills physicians possess and the special responsibilities they bear. Neither common nor uncommon morality, as Rhodes envisions the contrast, suffice for an account of complex ethical dilemmas such as those posed by the confidentiality of medical information.

Notes

1. Rhodes R. Medical ethics: Common or uncommon norality. *Cambridge Quarterly of Healthcare Ethics* 2020;29(3):404–20.
2. Baier A. Trust and antitrust. *Ethics* 1986;96(2):231–60.
3. See note 1, Rhodes 2020.
4. Dickens BM. Legal limits of AIDS confidentiality. *JAMA* 1988;259(23):3449–51.
5. Sugarman J. Bioethical challenges with HIV treatment as prevention. *Clinical Infectious Diseases* 2014;59(Suppl 1):S32–S34.
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7. Haire B, Kaldor JM. Ethics of ARV based prevention: Treatment-as-prevention and PrEP. *Developing World Bioethics* 2013;13(2):63–9.
8. Schuklenk U. The trouble with public health: HIV/AIDS in Canada as a case in point. *Bioethics* 2018;32(2):82.
9. Gonsalves GS, Copple JT, Johnson T, Paltiel AD, Warren JL. Bayesian adaptive algorithms for locating HIV mobile testing services. *BMC Medicine* 2018;16(1):155.
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11. Bogart LM, Ransome Y, Allen W, Higgins-Biddle M, Ojikutu BO. HIV-related medical mistrust, HIV testing, and HIV risk in the National Survey on HIV in the Black Community. *Behavioral Medicine* 2019;45(2):134–42.