"Dissecting Bioethics," welcomes contributions on the conceptual and theoretical dimensions of bioethics. The department is dedicated to the idea that words defined by bioethicists and others should not be allowed to imprison people's actual concerns, emotions, and thoughts. Papers that expose the many meanings of a concept, describe the different readings of a moral doctrine, or provide an alternative angle to seemingly self-evident issues are particularly appreciated. To submit a paper or to discuss a suitable topic, contact Matti Häyry at matti.hayry@aalto.fi and Tuija Takala at tuija.takala@helsinki.fi.

Medical Ethics: Common or Uncommon Morality?

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Abstract: This paper challenges the long-standing and widely accepted view that medical ethics is nothing more than common morality applied to clinical matters. It argues against Tom Beauchamp and James Childress's four principles; Bernard Gert, K. Danner Clouser and Charles Culver's ten rules; and Albert Jonsen, Mark Siegler, and William Winslade's four topics approaches to medical ethics. First, a negative argument shows that common morality does not provide an account of medical ethics and then a positive argument demonstrates why the medical profession requires its own distinctive ethics. The paper also provides a way to distinguish roles and professions and an account of the distinctive duties of medical ethics. It concludes by emphasizing ways in which the uncommon morality approach to medical ethics is markedly different from the common morality approach.

Keywords: common morality; medical ethics; medical professionalism; uncommon morality

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Introduction

People are often surprised when they learn that something they believed for a long time is not the case. When you make the discovery yourself, you may congratulate yourself on your cleverness and insight, but you may also regret decisions that you had made based on your mistaken belief. When someone else demonstrates the problems with a former belief, the surprise is likely to be accompanied by some

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embarrassment. "How could I have been so foolish as to believe that!" And when the informed person had actually shared the flawed notion with others, or encouraged others to adopt the criticized concept, as teachers are apt to do, rage may ensue. Some people may even wish to shoot the messenger.

With awareness of such possible results, this paper will challenge most bioethicists' longstanding attachment to the common morality view of medical ethics. In sympathy with their predicament, I confess that when I was young, I too had previously accepted the common morality approach. Over the years, however, I started to notice that this approach did not entirely cohere with good clinical practice. As counter-examples to the reigning view began to accumulate in my experience, I finally reached the conclusion that common morality and medical ethics were incompatible and that a new theory of medical ethics was needed.

The problem may have begun with terminology. By christening the field 'bioethics' instead of 'medical ethics,' early authors lumped together issues of public policy, personal morality, and medical professionalism. Public policy matters should be determined by reasons from common morality whereas personal morality decisions largely turn on an individual's personal commitments and priorities. Issues of medical professionalism are different from both matters of public policy and personal morality. It is precisely because the medical profession is fundamentally different from those other domains, that medical decisions require distinctly different reasons to support the ethical conclusions of medical professionals.

Public policy should be justified by reasons related to the flourishing of society, and supported by an overlapping consensus of the population. It is, however, totally acceptable for personal decisions to reflect the idiosyncratic values and priorities of the individual making a personal choice. So long as the chosen action harms no one else, no one else has to agree with it. Decisions about matters of medical ethics need not be endorsed by the general public or individuals outside of the profession. They should be supported, however, by an overlapping consensus of fellow medical professionals. They should not be regarded as matters of personal discretion; rather, decisions about matters of medical ethics should bind all medical professionals. Overlooking these significant differences, and treating these very different sorts of decisions with a homogenized approach, seems to have led to the application of common morality methodology to medical ethics.

In what follows, I argue for regarding medical ethics as a realm of morality that is separate and distinct from common morality. This position implies that the ethics of medicine should be governed by reasons that are different from both reasons that should guide public policy and those that may direct personal choices. In pressing this point, I will be building on a prescient article by Bernard Baumrin, "The Autonomy of Medical Ethics: Medical Science vs. Medical Practice." In that 1985 paper Baumrin follows philosopher G.E. Moore's example of arguing that ethics is an autonomous field and distinct from fields such as biology and physiology.[1] To explain what makes a field of knowledge autonomous, Baumrin writes:

> In philosophic circles such a question is usually put this way: is such and such domain or subject matter autonomous? In professional circles the language tends to be more metaphorical: is this or that subject matter merely an offshoot of some more fundamental study? … To say that such and such a subject is something on its own and not reducible to something else, some other

> intellectual endeavor, is to say it is an autonomous subject, and that means it is not fully reducible to some other subject, like metallurgy to chemistry, botany to biology, or even chemistry to physics. One domain is reducible to another … if its principles or theorems are deducible from the other domain. … [F]or the independence of some domain to be established there needs to be at a minimum a species of data *sui generis* to it. This, along with principles specific to the domain (i.e., not deducible from any other domain) establishes the autonomy of the discipline.[2]

In this sense, I will argue that medical ethics is an autonomous field. It is precisely because the duties of medical professionals are not derived from precepts of common morality or any other field, and because they cannot be deduced from common morality or personal ethics, that medical ethics is an autonomous field. As an independent moral domain that is not part of either common morality or personal ethics, the foundational commitments of the profession and the specific requirements of medical ethics have to be defined and explained with reasons supported by an overlapping consensus of rational and reasonable[3] medical professionals.

With the conceptual boundaries of personal, political, and professional ethics in mind, I will be presenting an argument that challenges the long-standing and widely accepted view that medical ethics is nothing more than common morality applied to clinical matters. Specifically, I will argue against the view that common morality explains the ethics of medicine to contest Tom Beauchamp and James Childress's four principles;[4] Bernard Gert, K. Danner Clouser and Charles Culver's ten rules;[5,6] and Albert Jonsen, Mark Siegler, and William Winslade's four topics[7] approaches to medical ethics. In other words, I will be committing bioethics heresy. I do not relish the idea of angering my fellow bioethicists, but, as I see it, there is a case to be made for a fresh approach to medical ethics.

In setting aside bioethics orthodoxy and rejecting the common morality approach to medical ethics, I recognize that my opposition to this long-standing tradition requires a robust defense. Here, I present my case. I focus on the work of Beauchamp and Childress, and Gert, Clouser, and Culver because their theories have received the most attention over the last decades. Although there has been a good deal of criticism of their work, my remarks tack in a different direction. My aim is not to take issue with specific arguments, but to show why common morality is untenable as an account of medical ethics. I begin by offering a brief account of the common morality approach to medical ethics. Then I present a negative argument to show that common morality does not provide an account of medical ethics. I follow that with a positive argument that demonstrates why the medical profession requires a distinctive ethics and provide an account of the source of medical ethics and its fundamental duties. I conclude by defending my position against possible critics who support the common morality view and resist acknowledging the distinctiveness of medical ethics.

Common Morality

The dominant common morality view of medical ethics was articulated by K. Danner Clouser in his *Encyclopedia of Bioethics* article on 'Bioethics,' where he explained that "bioethics is not a new set of principles or maneuvers, but the same old ethics being applied to a particular realm of concerns."[8] Common morality is the approach most prominently expounded by Tom Beauchamp and James Childress in their seven

editions of *Principles of Biomedical Ethics* (1979–2013) and adopted by Albert Jonsen, Mark Siegler, and William Winslade in the eight editions of *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine* (1982–2015). In their books, Beauchamp and Childress argue that the action-guiding norms of traditional ethical theories converge on a set of common morality norms "without argumentative support." They identify the four principles of respect for autonomy, beneficence, nonmaleficence, and justice as the "considered judgments that are the most well-established moral beliefs" to "serve as an anchor of moral reflection."[9] They then rely on those principles in their analyses of ethical issues arising in medicine. As recently as his 2014 chapter, "The Compatibility of Universal Morality, Particular Moralities, and Multiculturalism," Beauchamp has continued to maintain that particular moralities such as professions "*share the norms of common morality with all other justified particular moralities*" [italics for emphasis in the original].[10] In other words, Beauchamp holds fast to his view that professional ethics is common morality and it is nothing more than narrowly specified conclusions from common morality.

The common morality strategy is also embraced by Clouser and colleagues Bernard Gert and Charles Culver in *Bioethics: A Return to Fundamentals* (1997) and again in *Bioethics: A Systematic Approach* (2006). They identify ten moral rules as the crux of common morality: (1) Do not kill, (2) Do not cause pain, (3) Do not disable, (4) Do not deprive of freedom, (5) Do not deprive of pleasure, (6) Do not deceive, (7) Keep your promise, (8) Do not cheat, (9) Obey the law, (10) Do your duty.[11] They regard any apparent differences between common morality and medical ethics to be explained by their tenth rule that requires people to "Do your duty."[12] While they recognize that professions have "particular moral rules and special duties" they regard that difference as merely a matter of "culture."[13] Indeed, they maintain that,

> Many of the duties of a profession are particular applications of the general moral rules (which are **valid for all persons in all times and places**) in the context of the special circumstances, practices, relationships, and purposes of the profession. Thus, the duties are far more precise with respect to the special circumstances characterizing a particular domain or profession. [emphasis added][14]

In other words, they persist in their assertion that the rules of common morality explain professional ethics.

The Negative Argument: Common Morality Does Not Yield Medical Ethics

The common morality view that all bioethics is traditional ethics applied to novel circumstances, amounts to a universal claim. It asserts that there is nothing distinctive about medical ethics and that all of medicine's ethics is explained by common morality. According to the laws of logic, a single counter-example refutes a universal claim. Because I am challenging the deeply entrenched and widely accepted view that medical ethics is just common morality, here are a few counter-examples. Keep in mind that I only need to identify one compelling instance to show that the common morality universal claim is false.

1) If an acquaintance asks for some of your orange, or a colleague asks for your honey cake recipe, or a neighbor asks you to look after his pet while he is on vacation, you

may deny the requests. Your resources, knowledge, time, and effort are your own, and you need not relinquish them. Yet, when a fellow medical professional[15] requests medical resources, knowledge, or physical assistance for the care of a patient, the summoned professional is obliged to render the aid. That is because medical professionals have a positive duty to respond to patient needs even when it is for another physician's patient.

2) In everyday life people are free to make decisions anyway they like. You may choose to accept guidance from your horoscope, the flip of a coin, or rely on your gut feeling. Medical professionals, however, are expected to rely upon scientific evidence when they recommend treatment. Gut feelings and the like are not acceptable justifications for medical decisions.
3) In the course of ordinary social interactions, we freely share what we see or hear. Information sharing is useful, entertaining, and part of the fabric of our lives. Exceptions typically require explicit requests for keeping divulged information secret (e.g., promises, nondisclosure agreements). In medicine, at least since the time of Hippocrates, confidentiality is presumed, although some exceptions can be justified.
4) In ordinary life, we associate with whomever we choose. We distinguish between people based on character or reputation and avoid those who we do not like. But in medicine, professionals are supposed to be nonjudgmental and minister to every patient's medical needs without judgments as to their worth.
5) Most people today consider sexual activity among consenting adults to be ethically acceptable. In medicine, however, consent does not legitimize a physician's sexual involvement with a patient. We expect a patient's invitation for a tryst to be declined and that none would be issued to a patient by a medical professional.
6) In social situations, asking probing personal questions is regarded as rude. Yet, taking a complete and detailed patient history can include asking about a patient's diet, bowel habits, sexual preferences, drug use, previous illnesses, emotions, and fears.
7) The morality of ordinary life requires us to regard other adults as autonomous and respect their choices. Medical professionals, however, are not allowed to presume that patients are acting autonomously when they appear to be making poor health choices. Instead, they are responsible for vigilant assessment of patients' decisional capacity, and sometimes required to oppose patients' stated preferences.

These examples make the point that medical ethics is distinct and different from common morality. To summarize the differences that these counterexamples illustrate, the table below makes the dissimilarities glaring and explicit Table 1. This graphic depiction of the difference between the duties of medical ethics and common morality highlights our different expectations for the behavior of medical professionals and others.

If common morality and medical ethics were the same, then the ethically justified behavior for medical professionals and everyone else would be the same. But, as the table illustrates, they are not. If common morality explained medical ethics, logically, the same

Table 1. The Distinctiveness of Medical Ethics

Counterexamples	Duties of Medical Ethics	**Common Morality** *versus* **Medical Ethics**
1. Look after your own interests	Be responsive to requests from medical professionals	A moral **ideal** is transformed into a **duty**
2. Make choices your own way	Guide choices with scientific evidence	A moral **ideal** is transformed into a **duty**
3. Share information	Confidentiality	**Permissible** behavior is **impermissible**
4. Judge the worth of others	Nonjudgmental regard	**Permissible** behavior is **impermissible**
5. Enjoy sexual interaction	Nonsexual regard	**Permissible** behavior is **impermissible**
6. Mind your own business	Probe (with examination, tests, and questions)	**Impermissible** behavior is a **duty**
7. Presume others have autonomy	Assess decisional capacity	**Impermissible** behavior is a **duty**

premises would lead to the same conclusions for everyone. The marked differences in what is optional for ordinary people and required for medical professionals, and the radical differences in behavior that is acceptable and unacceptable for medical professionals and others, demonstrate that the ethics of everyday life is significantly different from the ethics of medicine in dramatic and important ways. In the absence of a robust explanation for how the same premises lead to contradictory conclusions for medical professionals and others, we should acknowledge that common morality is not consistent with medical ethics.

If any of my examples of the difference between common morality and medical ethics is persuasive, then either the situations are different for medical professionals and others in an ethically significant way, or the involved moral duties are different, or both. As I see it, the facts that the actions are performed by medical professionals in a professional context are significant differences that go a long way toward explaining the ethical differences. This implies that medical professionals should not rely upon common morality to guide their practice or resolve their ethical dilemmas. Instead, they should be governed by standards of medical ethics and professionalism.

In addition, it is hard to see how the different duties of medical professionals could be explained by invoking the four principles or ten rules because common morality concepts do not figure into explaining professional duties. Reasons that are specific to medical practice explain those specific duties, making common morality largely irrelevant in my examples. In other words, common morality does not account for why medical ethics requires nonjudgmental regard, nonsexual regard, confidentiality, or the rest.

Beauchamp and Childress as well as Gert, Culver, and Clouser do speak of circumstances, such as professions, in which moral ideals are transformed into duties. They never explain why or how that significant transformation occurs, or how aspirational behavior

becomes a strict obligation. They offer no account of when and how the transformation is accomplished, no rationale to justify and explain those radical changes, and persist in maintaining that common morality is doing the explanatory work.

Even though the distinction between common morality and medical ethics is hardly mentioned in their analyses, early on in their book Beauchamp and Childress do suggest that there are "particular moralities" including "professional moralities" that vary from common morality. They also accept that some ideals of common morality become requirements for people in professions "by their commitment to provide important services to patients, clients, or consumers."[16] Although they state that "professional roles engender obligations that do not bind persons who do not occupy the relevant professional roles,"[17] they never explain what that commitment is, how it comes about, or what the specific obligations are. Granting that moral ideals can become demands of the moral life and that "[s]pecial roles and relationships in medicine require rules that other professions may not need,"[18] they nevertheless follow Jay Katz in dismissing the value of medicine's "visionary codes of ethics."[19]

In this light, the section on "Negligence and the Standard of Due Care" in their chapter 5 on "Nonmaleficence," is particularly illuminating. There Beauchamp and Childress enumerate four essential elements of negligence that define violations of the responsibility to exercise due care:

1) The professional must have a **duty** to the affected party.
2) The professional must breach that **duty**.
3) The affected party must experience harm.
4) The harm must be caused by the breach of **duty**. [*emphasis added*][20]

Their list implicitly concedes my point: It is because medical professionals have distinctive duties that their actions must be judged by a different standard than what would otherwise apply. Absent the **un**common professional duties, Beauchamp and Childress would be unable to explain medical malpractice because the ground for professional responsibilities is not common morality. The source of these distinctive obligations is the commitment to take on the duties of a medical professional.

Similarly, Gert, Culver, and Clouser maintain that their ten rules of common morality provide an account of medical ethics. Aside from granting that changes in responsibility are "largely set by the medical profession, though perhaps clarified and modified by law and society,"[21] Gert, Culver, and Clouser say little to explain how medical professionals become bound to conform with professional duties that are diametrically opposed to what others should do. They would assert that the "moral rules" of preventing death, pain, disability, loss of pleasure, and loss of freedom and the "moral ideals" that encourage people to engage in actions to prevent or relieve such harms go a long way toward explaining my examples.[22] But, the transformation from an ideal of beneficence to a strict duty, or, in Kantian terms, from an imperfect to a perfect duty, is a significant difference and not easy to explain.

Gert, Culver, and Clouser would also argue that their seventh rule, "Keep your promise,"[23] explains the responsibilities of medical professionals in my examples. Whereas that rule might account for a moral ideal becoming a stringent moral requirement for someone who makes a promise to uphold it,

I do not see how promising radically changes the content of moral responsibility from something to its opposite when the conclusion is supposed to be derived from the same rules.

It also appears that Gert and colleagues missed their own point about the medical responsibility to assess patients' decisional capacity, and failed to notice how it creates a problem for their common morality approach to medical ethics. Their numerous examples and astute analysis of medical paternalism demonstrates that they regard assessment of decisional capacity as a medical responsibility. Yet, their rules four and five prohibit deprivations of freedom or pleasure.[24] Their own examples illustrate the inconsistency.

For instance, they describe an elderly depressed woman who lost a lot of weight. She understands and appreciates her life threatening situation and acknowledges that an irrational fear keeps her from consenting to the electroconvulsive treatment that she knows is likely to cure her depression.[25] They therefore conclude that the woman lacks decisional capacity and electroconvulsive treatment should be administered over her objection. Thus, acknowledging medical professionals' duty to assess capacity and paternalistically promote patients' interests opposes common morality responsibilities to avoid deprivation of freedom or pleasure. Although I fully agree that medical professionals have the duty to assess decisional capacity, that obligation is clearly at odds with their rules, and it cannot be derived from common morality.

Setting the Stage for the Positive Argument: Roles, Professions, and Professional Ethics

Although common morality advocates casually acknowledge that professional responsibility is somehow involved in medical ethics, they pointedly deny its centrality. They also fail to distinguish social and institutional roles from professions.[26] Role morality (e.g., being a butcher, a baker, a candlestick maker) is consistent with common morality, and anyone may perform the activities of people who have those roles. Hunters and farmers may butcher their own meat, I may bake my own cookies, and my grandchildren may fashion candlesticks for me as a craft project. Special role-related obligations (e.g., being a pet owner or parent), derive from individuals' voluntarily assuming special responsibilities by making an explicit or implicit promise.[27] Anyone who chooses to accept those roles takes on the duties associated with those roles. All of those role-related obligations are governed by common morality. The starting point for recognizing that medicine requires its own distinctive morality lies in appreciating that medicine is not a role but a profession, and what that means.

Social scientists define professions by describing what they see. Sociologist Talcott Parsons, for example, observes that professions involve "a cluster of occupational roles, that is, roles in which the incumbents perform certain functions valued in the society," and that they typically provide a livelihood and may have their own codes and oaths, their own technical language, and sometimes their own uniforms.[28] All of that is interesting, but then we need to consider why that is so.

Professions are different from roles in that the powers, privileges, and immunities which society allows to professions are radically different from what is allowed for ordinary citizens.[29] The extraordinary liberties granted to professionals are potentially dangerous, so, aside from remarkably unusual circumstances, ordinary citizens are

prohibited from performing the acts that professionals are allowed to carry out under normal circumstances.

Because the commissions granted to professionals (like causing pain, disability, or hastening death) are not standardly allowed to anyone outside of the professions, the duties of medical professionals are not covered by common morality. Because professional powers and privileges lie outside of what is allowed for nonprofessionals, there are no common morality principles or rules governing their legitimate use. Professional duties therefore must be conceived and articulated, and the limitations on how the profession's distinctive authority may be employed must be delineated and explained from a perspective outside of common morality.

Whereas any adult may butcher his own meat, bake her own cakes, and make his own candlesticks, or take on duties of pet owner or parent, only medical professionals are permitted to perform surgery, only those in the military may explode bombs in order to kill other humans, and only priests may grant absolution. To be trusted with the remarkable freedoms that society allows members of professions, each profession (e.g., medicine, the military, the clergy) must articulate its own profession-specific moral rules for managing those extraordinary liberties and describe the distinctive professional character required from its members.

The Positive Argument for the Distinctiveness of Medical Ethics

Medical professionals certainly have a good deal of specialized knowledge. They understand much more than many others about anatomy, physiology, immunology, pathology, pharmacology, genetics, microbiology, genomics, biochemistry, and so on. They also have a host of special skills. But the knowledge and skills bestow neither rights nor responsibilities. Medicine's extraordinary powers, privileges, and immunities come from individuals accepting their unique duties. Fulfilling those undertaken obligations entails wielding distinctive powers, privileges and immunities. Because the profession's core responsibilities could not be accomplished without that special license, the means for accomplishing the desired ends must be granted to those who are allowed to take on the duties of the profession.

A thought experiment can help flesh out this view. We can begin by imagining how medicine came about and seeing what we can learn from the exercise. Imagine people in early civilizations who were aware that they and their loved ones could suffer injury or succumb to disease. They wanted guidance for avoiding those conditions and help in addressing the consequences such as pain, disability, and death, when disease or injury occurred. They therefore allowed some people to develop knowledge of fields we now call anatomy, physiology, pharmacology, and so on, and develop examination and surgical skills. To enable medical professionals to accomplish the goals of using their special knowledge and skill in meeting the needs of people in their communities, societies granted medical professionals the necessary powers, privileges, and immunities permitted to no one else. Medical professionals' powers include the authority to quarantine people in order to prevent the spread of infectious disease, to determine death, and to decide that someone lacks decisional capacity and impose treatment over his objections. Medical professionals' privileges allow them to ask strangers to undress, concoct and administer poisonous substances, and cut into bodies to remove tissue. And medical professionals' immunities protect them from

Table 2. Distinctive Features of Medicine Required for the Fulfillment of Medicine's Duties

Powers	Determine lack of decisional capacity
	Impose treatment over objection
	Deprive people of freedom (i.e., involuntary commitment)
Privileges	Ask probing questions
	Examine nakedness
	Image insides
	Prescribe and administer medication (i.e., poison) or treatments
	perform surgery (i.e., assault with deadly weapons)
	Inflict pain
Immunities	From prosecution for employing powers and privileges
	From prosecution for untoward outcomes

punishment for exercising their extraordinary powers and privileges or causing harms (e.g., pain, disability, death) with their efforts.

In other words, by accepting their professional duties, medical professionals become duty-bound to ask patients probing questions, examine their nakedness and prescribe needed but dangerous drugs. Failing to employ necessary professional powers and privileges (e.g., performing a rectal exam) is likely to be a failure of duty. Also, employing the powers and privileges of the profession when they are not needed (e.g., gratuitously inflicting pain during an examination) would also be a violation of duty.[30]

Because the powers, privileges and immunities allowed to medical professionals and no one else are potentially dangerous, society demands that they be used in a trustworthy way.[31] As physician Edmund Pellegrino appreciated, "The doctor voluntarily promises that he can be trusted and incurs the moral obligations of that promise."[32] It is also imperative for medical professionals to demonstrate their commitment to using their distinctive dispensations exclusively to serve the interests of patients and society, and observe the professional limitations on their professional behavior. Together, the profession's public declarations of moral commitment, coupled with a history of behavior constrained by medical ethics, enables society to trust medical professionals in wielding their extraordinary prerogatives.

Because people with medical needs make themselves vulnerable by trusting medical professionals and medical institutions based on their professional status, the first and fundamental duty of medical ethics must be to seek trust and be deserving of it. The second duty of medical ethics constitutes medicine's fiduciary responsibility, that medical professionals must use their medical knowledge, skills, powers and privileges only to advance the interests of patients and society. Several specific duties of medical ethics follow from medical professionals' foundational duties. Those more specific duties are justified as necessary means to achieve or maintain trust. Thus, medicine's two fundamental duties are the source and foundation from which additional duties of medical ethics are derived, and they provide the rationale or moral force behind the profession's additional, more specific, duties Table 3.

Table 3. Duties of Medical Ethics

1)	**Seek trust and be deserving of it**
2)	**Use medical knowledge, skills, powers, privileges and immunities to advance the interests of patients and society**
3)	Develop and maintain professional competence
4)	Provide care based on need
5)	Be mindful in responding to medical needs
6)	Base clinical decisions on scientific evidence
7)	Maintain nonjudgmental regard toward patients
8)	Maintain nonsexual regard toward patients
9)	Maintain the confidentiality of patient information
10)	Respect the autonomy of patients
11)	Assess patients' decisional capacity
12)	Be truthful in your reports
13)	Be responsive to requests from peers
14)	Communicate effectively
15)	Police the profession
16)	Assure justice in the allocation of medical resources

Medical professionals are the ones who define professional duties because they are the only ones who adequately understand what is involved. They can appreciate the potential risks and benefits of their services and distinguish competent practice from unacceptable performance. Therefore, the ethics of medicine is internal to the profession: It is constructed by the profession, for the profession, and needs to be continually critiqued, revised, and reaffirmed by the profession. In opposition to common morality accounts, this construction argues for recognizing medical ethics as a domain of ethics that is distinct and different from common morality.[33] Taken together, the negative and positive arguments generate the need for a new theory of medical ethics to explain medical professionals' distinctive responsibilities. In the examining room and at the bedside, patients expect medical professionals to uphold standards of medical professionalism and display character traits and attitudes that go beyond requirements of common morality. Without being able to rely on clinicians cleaving to the standard of care, being nonjudgmental, respectful, caring, upholding confidentiality, maintaining professional competence, and regulating the profession, patients would have to be guarded and skeptical in their interactions with medical professionals, thereby undermining the good that medicine can provide. And without a clear articulation of their duties, medical professionals are left without a rudder to struggle through ethical issues when better moral guidance should be provided.

Medical Professionalism

Over the past twenty or so years, there has been considerable discussion of medical professionalism. Several authors who discuss professionalism recognize that something akin to a social contract is involved and that trust is necessary for the practice of medicine. Yet, there has been some disagreement within the academic medicine and medical education communities about what medical professionalism is [34,35,36,37,38,39,40] and how it should be incorporated into medical

training.[41,42,43,44] Some argue that professionalism is about rules,[45,46,47,48] others maintain that it is about virtues, character, or beliefs,[49,50,51,52] and others hold that it is about achieving [measurable] competencies.[53,54,55,56] The disagreement is understandable because professionalism is a complex amalgam of all these elements.

The critical point that has not been adequately appreciated is that the concept of medical professionalism is derived from the distinctive ethics of medicine. Professionalism is needed because it commits medical professionals to ethical standards that are different from and more demanding than those of common morality. It requires them to understand their distinctive professional duties and be able to apply them in their practice. It entails medical professionals embracing their unique obligations, identifying with them, and accepting the responsibility to fulfill them with a sincere commitment. In that sense, it involves developing a character that takes pleasure in fulfilling professional obligations and a commitment to moderating desires that might interfere with upholding professional duties. In sum, **professionalism is medical professionals' personification of medical ethics**. Professionalism involves understanding the obligations of a medical professional, making oneself into a person who is likely to fulfill those duties, and acting in accordance with the dictates of medical ethics. The hallmark of medical professionalism is the commitment to and the internalization of medicine's distinctive ethics. Because medical ethics is radically different from common morality, it has to be inculcated and policed by the profession.

Why Is Medical Ethics Not Merely Common Morality?

At this point, I imagine that some common morality advocates may suspect that what I'm calling uncommon professional ethics is merely common morality. My list of duties of medical ethics looks like mothers' milk, and common morality also looks like mothers' milk. Furthermore, they might protest that the four principles could account for all of the duties on my list. So let me try to correct that stubborn perspective.

Trust: People outside of the medical professions may see value in seeking the trust of others and developing a reputation for trustworthiness. In common morality it may be prudent to pursue trust and nice to be worthy of trust, but it is not a requirement of duty. When society grants medical professionals special powers, privileges, and immunities, the license persists only on condition of trustworthiness and only so long as the profession can maintain that trust. Therefore, medical ethics is different from common morality because seeking trust and being trustworthy are defining elements of professional morality.

The Four Principles: To a common morality advocate, the duties I enumerated seem to be derived from common morality. Medicine's fiduciary responsibility to advance the interests of patients and society may look like common morality's beneficence. But within the realm of professional morality, advancing the interests of patients and society is not merely an ideal: It is a duty. In common morality, only nonmaleficence is a duty, whereas beneficence is nice but optional. For medical professionals, promoting the interests of patients and society is required as a strict and defining obligation: It is not optional.

Fiduciary responsibility is the hallmark of a profession, and a distinguishing feature of professions. Society grants special powers, privileges, and immunities to professions only on the condition that they be used for the good of others.

When those licenses are used to advance personal interests and to the detriment of others, those powers, privileges, and immunities are stripped away, and whoever abuses professional status is rendered vulnerable to the penalties that would be imposed on those outside of the profession. The use of the liberties that professionals are permitted is restricted to the purposes that serve the interests of patients and society. Otherwise, they may not be employed.

Many actions by medical professionals involve both benefits and harms, requiring professionals to evaluate and balance them in determining what serves the interests of a patient. In medicine, determining what serves the interest of a patient is always a matter of judgment, and evidence-supported judgments that identify interventions that serve the interests of patients with similar needs become the standard of care. Focusing on common morality principles of beneficence and nonmaleficence, however, makes these decisions baffling because they always involve dilemmas with no obvious resolution. For example, strictly attending to beneficence and nonmaleficence can make it difficult to justify a standard procedure like mammography. Mammography always causes harm in that it is inconvenient, painful, and anxiety inducing. It also only rarely provides a benefit because early detection is no benefit to patients who never develop breast cancer. In other words, the common morality framework is more complicated and less clear than a useful moral guide should be.

Furthermore, whereas the common morality concept of beneficence applies broadly to every sort of benefit, the fiduciary duties of medicine focus on the narrow range of benefits that are produced through the exercise of medicine's distinctive powers and privileges. Consider a person who trips on a cracked sidewalk, falls, and files a lawsuit to be compensated for pain and suffering, lost wages, medical expenses, and disability.[57] It would certainly benefit her to collect a large payment from the insurance company. Her chance of having a successful claim and receiving a lucrative settlement is likely to turn on an orthopedic surgeon's assessment. Nevertheless, the examining orthopedic surgeon who finds that the person's knee pain and needed knee replacement surgery are related to osteoarthritis and not trauma should honestly report the findings. The truthful report will fail to benefit the patient and may even expose the patient to some harmful legal liability. From the common morality perspective, this circumstance raises an ethical dilemma. Medical ethics, however provides a clear answer. The scope of serving patient interests is limited to actions that involve employment of the profession's distinctive powers and privileges; it does not extend to providing patients with financial benefits. Also, the profession's commitment to trustworthiness requires truthful reporting of medical findings, and society's interests are served by being able to rely upon the truthful reports of medical professionals.

Intransigent common morality supporters may also be suspicious of my claims for the distinctiveness of medical ethics because respect for autonomy is a feature of common morality, and it appears on my list of medical duties. They should notice, however, that in medical ethics respect for autonomy is paired with the duty to assess decisional capacity, which is not a feature of common morality. This difference reflects a significant difference in the circumstances of medical practice and the typical encounters of everyday life. The decisions to accept or refuse medical treatment that patients are called upon to make are likely to be much more serious and have more enduring

consequences than many other decisions. Also, when patients have to make medical decisions, they are more likely than otherwise to be in the grips of fear, overwhelmed by depression, or overcome by psychosis, denial, or repression, and often enough decisions have to be made quickly. In addition, patients' cognitive abilities may be impaired by unconsciousness, disease, or drugs rendering them incapable of reaching the decisions that they would make when not hindered in those ways. Combined, these factors demand the scrutiny and assessment of medical professionals that give paternalism a significant role in clinical practice although it has little place in other social interactions.

Attention to justice in both common morality and medical ethics could also encourage critics to conflate common morality and medical ethics. Sorting out what is owed and to whom turns out to be a far more complicated and contextual matter than common morality supporters may appreciate. It should be noted that concepts of retribution, rectification, and reciprocity that are important considerations of justice in common morality are unacceptable considerations in medicine. Medical ethics only addresses matters of distributive justice, and even there, some principles of justice that are appropriate in everyday life are ruled out as grounds for allocation decisions in clinical medicine and public health. For example, in common morality, justice allows rewarding people for their past achievements, promoting people who show promise of future achievements, and bestowing special invitations and favors on our favorites. Medical justice, however, requires nonjudgmental regard and equal treatment for all with similar medical needs. In other words, some considerations that are relevant in common morality allocations must be eschewed in the just allocation of medical resources. It is ethically important to recognize that common morality conceptions of justice do not apply to allocations of resources in medicine.

Rationale: The rationale that supports common morality is different from the underpinning for medical ethics. Common morality is justified by what an overlapping consensus of rational and reasonable people would endorse in reflective equilibrium or by a conception of what no rational person could reasonably refuse to endorse.[58] That means common morality binds everybody, or at least all of those who are rational and reasonable. The moral force that creates medical ethics is, however, the commitment of medical professionals to promote the interests of patients and society. It is precisely because **not** everyone, but only medical professionals, make that commitment that only medical professionals are committed to upholding medical ethics.

Methods: Both Beauchamp and Childress, and Gert, Culver, and Clouser maintain that their principles or rules, which provide moral guidance for all people "all of the time, in all times and places,"[59] also provide the moral guidance for medical professions. Their methods for reaching conclusions about what to do involve a convoluted, burdensome process of enumerating, justifying, and explaining. Common morality therein leaves the requirements of medical duty unspecified, and that lacuna invites disagreements and breaches of duty because medical professionals can legitimately claim ignorance of being bound by duties they have neither identified nor acknowledged.

Beauchamp and Childress recognize that the vagueness of their four principles leads to inconsistency and actually embrace the inevitable resulting disagreement, declaring that they remain

skeptical of the possibility of providing "a unified foundation for ethics."[60] In the 2009 sixth edition of *Principles of Biomedical Ethics*, they unambiguously express their acceptance of that result, stating, "we regard disunity, conflict, and moral ambiguity as pervasive features of the moral life that are unlikely to be eradicated by moral theory."[61] Whereas acceptance of the resulting variety of views may be a virtue in the politics of a liberal pluralistic society, leaving individual medical professionals to interpret, balance, specify, and generalize in decisions on common questions of medical ethics is problematic. The resulting "untidiness, complexity, and conflict"[62] may be tolerable or even advantageous in public debates and academic ivory towers, but patients need to know the parameters of what is reasonable to expect from those who provide their medical care, and medical professionals need at least clear signposts for navigating the complicated terrain of clinical practice.

Also, the application of common morality principles or rules to my seven initial examples requires a good deal of unpacking and justification. Expecting medical professionals to integrate and analyze the implications of ten rules is burdensome and perilous. Society reasonably expects moral clarity from medical professionals. People rely on them to understand their obligations and efficiently apply medical ethics to the circumstances of their clinical practice.

Conclusion

In this discussion I have made the case for disengaging medical ethics from common morality. I have also suggested that medical ethics provides the core and substance of medical professionalism. That said, the specific duties and virtues that constitute medical ethics still need to be more fully articulated, explained, justified, and illustrated with examples that can help medical professionals understand their professional obligations and how they may be fulfilled. The fuller account should cohere with the laudable elements of clinical practice, explain why they are correct, and explain why some positions and behaviors that have recently been accepted by some within the profession are actually unacceptable. Such a presentation would add up to a theory of medical ethics by illuminating the profession's distinctive duties and providing the professionals who require that guidance with an understanding of how medical professionalism can be achieved.

Notes

1. Moore GE. *Ethics*. New York, NY: H. Holt; 1912.
2. Baumrin BH. The Autonomy of Medical Ethics: Medical Science vs. Medical Practice. *Metaphilosophy* 1985;16,2&3: 93–102.
3. Here I am using the terms 'rational,' 'reasonable,' and 'overlapping consensus' in the technical sense that John Rawls ascribes. Rawls J. *Political Liberalism*. New York, NY: Columbia University Press; 1993.
4. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*, 7th ed. New York, NY: Oxford University Press; 2013.
5. Gert B, Clouser KD, Culver CM. *Bioethics: A Return to Fundamentals*. New York, NY: Oxford University Press; 1997.
6. Gert B, Culver CM, Clouser KD. *Bioethics: A Systematic Approach*. New York, NY: Oxford University Press; 2006.
7. Jonsen AR, Siegler M, Winslade WJ. *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*, 8th ed. New York, NY: McGraw-Hill Education; 2015.
8. Clouser KD, Bioethics. In: W. Reich, ed. *Encyclopedia of Bioethics*, 1st ed. New York, NY: The Free Press; 1978:532–42.
9. See note 4, Beauchamp, Childress 2013:407–8.
10. Beauchamp TL. The compatibility of universal morality, particular moralities, and multiculturalism. In: Teas W, Gordon J, Renteln AD, eds. *Global Bioethics and Human Rights*. Plymouth, UK: Rowan & Littlefield; 2014: 34.
11. See note 6, Gert et al. 2006, at 34.
12. See note 6, Gert et al. 2006, at 36.

13. See note 6, Gert et al. 2006, at 208.
14. See note 6, Gert et al. 2006, at 89.
15. I take the ethics of medicine to extend broadly and inclusively across the several medical professions and apply to all medical professionals, such as, for example, nurses, physicians, pharmacists, genetics counselors, physical therapists, social workers, chaplains, bioethicist, and so on.
16. See note 4, Beauchamp, Childress 2013, at 7.
17. See note 4, Beauchamp, Childress 2013, at 46.
18. See note 4, Beauchamp, Childress 2013, at 6.
19. See note 4, Beauchamp, Childress 2013, at 8.
20. See note 4, Beauchamp, Childress 2013, at 155.
21. See note 6, Gert et al. 2006, at 92.
22. See note 6, Gert et al. 2006, at 43.
23. See note 6, Gert et al. 2006, at 36.
24. See note 6, Gert et al. 2006, at 36, and 12.
25. See note 6, Gert et al. 2006, at 222.
26. In the ethics literature, roles and professions are often lumped together (e.g., Gibson K. Contrasting role morality and professional morality: implications for practice. *Journal of Applied Ethics* 2003;20(1):s17–29.
27. Role morality and 'voluntarism' are discussed by numerous authors, e.g., Hardimon MO. Role obligations. *The Journal of Philosophy* 1974;91(7):333–63; Simmons AJ. External justifications and institutional roles. *The Journal of Philosophy* 1996;93(1):28–36; Cane P. Role responsibility. *The Journal of Ethics* 2016;20(1–3):279–98; Baril A. The ethical importance of roles. *The Journal of Value Inquiry* 2016;50 (4):721–34; MacKay D. Standard of care, institutional obligations, and distributive justice. *Bioethics* 2015;29(4):262–73; Stern RA. "My station and its duties": Social role accounts of obligation in green and bradley. In: Ameriks K, ed. *The Impact of Idealism*: Volume 1, Philosophy and Natural Sciences. New York, NY: Cambridge University Press; 2013;299–322.
28. Sociologists like Talcott Parson define 'profession' by cataloging what they observe about professions. Parsons T. *Essays in Sociological Theory*, Revised ed. Glencoe, IL: The Free Press; 1993:372. The literature on professions largely follows the lead of those sociologists. (e.g., Latham SR. Medical professionalism: a parsonian view. *Mount Sinai Journal of Medicine* 2002; 69(6):363–9.
29. Alan Tapper and Stephan Millet and also W. P. Metzger take positions that are, in some respects, similar to mine on this issue. Tapper A, Millett S. Revisiting the concept of a profession. *Research in Ethical Issues in Organisations* 2015; 13:1–18. Metzger W P. What is a profession. *College & University* 1976; 52 (1):42–55.
30. This point was noted by Dr. Daniel Moros in conversation.
31. Here I am distinguishing professional ethics from both common morality and what has been called 'role morality.' It is because a profession is permitted special powers, privileges, and immunities that it requires distinctive rules for the regulation of those distinctive powers, privileges, and immunities.
32. Pellegrino ED. Professionalism, profession and the virtues of the good physician. *The Mount Sinai Journal of Medicine* 2002;69 (6):378–84.
33. On this point, I regard my position to be in line with similar stands taken by a handful of others including Hippocrates, Thomas Percival, John Gregory, and more contemporary authors such as David Thomasma, Edmund Pellegrino, Bernard Baumrin, Robert Baker, Lance Stell, and Lawrence McCullough.
34. American Board of Medical Specialties. Ethics and Professionalism Committee–ABMS Professionalism Work Group. ABMS Professionalism definition.
35. Wear D, Kuczewski MG. The professionalism movement: can we pause? *American Journal of Bioethics* 2004;4:1–10.
36. Hafferty F, Papadakis M, Sullivan W, Wynia MK. *The American Board of Medical Specialties Ethics and Professionalism Committee Definition of Professionalism*. Chicago, IL: American Board of Medical Specialties; 2012.
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57. This example was provided by Dr. Ronald Grelsamer.
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59. See note 6, Gert et al. 2006, at 11.
60. See note 4, Beauchamp, Childress 2013, at 396.
61. See note 4, Beauchamp, Childress 2013, at 374.
62. See note 4, Beauchamp, Childress 2013, at 374.