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ARTICLE

The Uncommon Ethics of the Medical Profession: A Response to My Critics

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Abstract
In responding to my critics, James Childress, Tom Beauchamp, Soren Holm, and Ruth Macklin, I reprise my arguments for medical ethics being an uncommon morality. I also elaborate on points that required further clarification. I explain the role of trust and trustworthiness in the creation of a profession. I also describe my views on the relationship of the medical profession to the society in which medicine is practiced. Finally, I defend my claim that medical ethics "is constructed by medical professionals for medical professionals" by describing the profession's unique vantage point for regulating and policing the profession's uncommon powers and privileges.

Keywords: common morality; uncommon morality; medical ethics; James Childress; Tom Beauchamp; Soren Holm; Ruth Macklin

Uncommon Morality

In my recent book, *The Trusted Doctor: Medical Ethics and Professionalism*,[1] and in articles defending my novel approach to medical ethics,[2,3,4] I provide two arguments for regarding medical ethics as a distinct domain of ethics that is markedly different from common morality. As a field of philosophy, ethics is committed to seeking truth and abiding by the laws of logic, the foremost being the law of noncontradiction. Ethics is primarily devoted to explaining what makes actions right or wrong, what makes an agent good or bad, and providing a systematic way to determine what a person should do or not do. Medical ethics is clearly part of the domain of ethics in that it relies on and employs basic moral concepts such as promising and duties. It also focuses on both actions and the elements of character that facilitate medical professionals' right action.

I have argued that the ethics of medicine is an autonomous field because (1) it cannot be derived from the ethics of everyday life, and because (2) the obligations of medical professionals are specific to the field. It should, therefore, be recognized as a distinct and different domain from the ethics that governs actions outside of the medical profession.[5,6] As an independent domain of ethics that stands apart from both common morality and personal ethics, the moral commitments of medicine and its specific ethical requirements have to be defined and explained with reasons that are unique to that profession. Borrowing a phrase from Leonard Fleck,[7] we need to acknowledge that medical ethics, as well as the moral requirements of other professions, are each distinct species of ethics that cannot be deduced from any other domain of morality (see Figure 1).

Although taking on any role involves a personal commitment to doing certain things or performing them with greater diligence and consistency than would otherwise be demanded of people in ordinary circumstances, professional obligations are markedly different from roles. Even though a person who assumes a role may have a stringent duty in a situation in which others have freedom, roles are consistent with common morality. A person who takes on a role is not allowed to violate common morality.

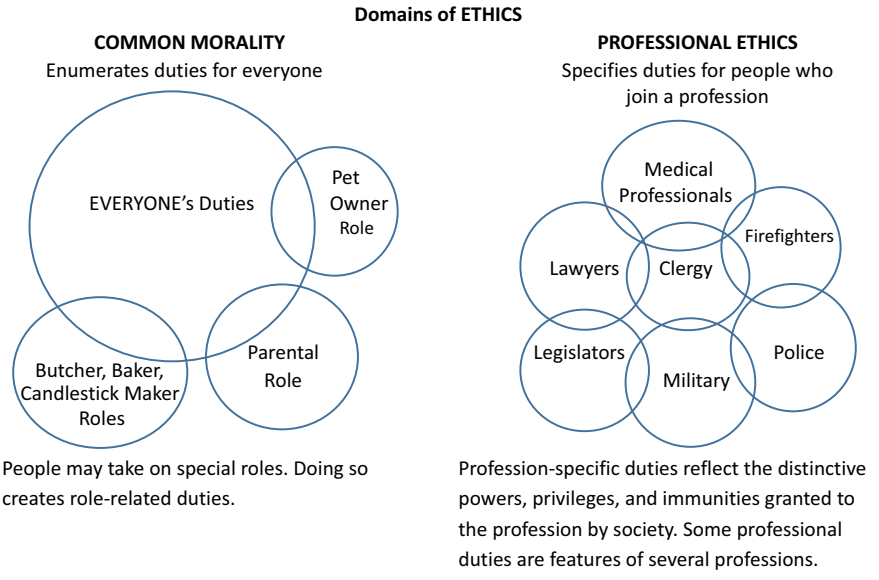

Figure 1. Domains of ethics.[9]

Professional roles, however, involve duties to perform actions that are incompatible with common morality and punishable when performed by anyone outside of the profession (aside from exculpatory circumstances).

As Ruth Macklin recognizes,[8] firefighters are granted the extraordinary powers to break down doors and enter private homes without permission, flood and destroy private property, physically move people without their consent, and establish costly requirements on housing construction. They are also obliged to enter burning buildings when others have no similar duties. Contra Macklin, I regard firefighting as a profession precisely because firefighters are allowed to perform actions that others are not generally permitted to do and because firefighters have obligations to perform services that others are free to avoid. For comparable reasons, and whether they acknowledge their responsibilities or not, I consider members of the military, police, lawyers, clergy, and lawmakers to all be professionals governed by their own distinctive morality.

For the most part, professional ethics and common morality function harmoniously side by side with each prodding the other to evolve with currents of social change, scientific advances, and technological developments. Medical ethics stands apart from other species of professional ethics by identifying the unique duties of people who join the profession and directing the choices that all medical professionals (e.g., doctors, nurses, genetic counselors, nutritionists, pharmacists, physical therapists, social workers, psychologists, and clinical ethicists) must make in fulfilling their distinctive professional obligations. Neither common morality nor any other species of ethics provides the perspective for answering the moral questions that medical professionals have to address.

How I Understand Common Morality

In the eight editions of *Priniciples of Medicial Ethics,* Tom Beauchamp and James Childress consistently assert the following universal claim about "common morality."

> Some core tenets found in every acceptable particular morality are not relative to cultures, groups or individuals. All persons living a moral life know and accept rules such as not to lie, not to kill or cause harm to others, to keep promises, and to respect the rights of others. All persons committed to morality do not doubt the relevance and importance of these universally valid rules. …

> We call the set of universal norms shared by all persons committed to morality *the common morality*. This morality is not merely a morality, in contrast to other moralities. It is applicable to all persons in all places, and we appropriately judge all human conduct by its standards.[10]

In that spirit, they also assert that professional norms "*are not morally justified if they violate norms in the common morality.*"[11] They identify the four principle of respect for autonomy, nonmaleficence, beneficence, and justice as the broad principles on which to build biomedical ethics. They add a process of specification and balancing to their claim and principles, and incorporate numerous additional concepts and terms borrowed from other authors.[12] To avoid distorting their view, I will avoid any further characterization.

My Argument for Medical Ethics being an Uncommon Morality

(1) Logically, a single counter-example is sufficient to disprove Beauchamp and Childress's universal claim that all ethics (including medical ethics) is included in common morality. The *negative argument* that I offer in defense of my claim that medical ethics is an uncommon morality consists of several counter-examples to illustrate the numerous differences in the moral requirements for medical professionals as compared to everyone else. Some actions prohibited for nonprofessionals in everyday life (e.g., killing [a primary example for Beauchamp and Childress], administering poisons, probing strangers' intimate body parts) are often required of medical professionals. Some actions permitted in everyday life (e.g., preferential treatment of loved ones, forming judgments as to who is worthy of your attention) are prohibited for medical professionals. And some actions that are ideals, but optional, in everyday life (e.g., demonstrating caring concern) are obligatory for medical professionals. Although we see a good deal of overlap in what common morality and medical ethics identify as right or wrong action, the points on which one is more stringent than the other, and the positions on which they are diametrically opposed, demonstrate that common morality does not provide the ethics of medicine.

Medical professionals may have duties to hasten death (i.e., kill) in response to requests from competent patients (e.g., to turn off an implanted pacemaker for a device-dependent patient, to provide an increased dose of morphine for a patient in agony) that others would not be permitted to do. At the same time, medical professionals would violate professional duties by not taking action to preserve life by offering a pacemaker to a patient with a heart condition that required such assistance or by failing to calculate opioid dosage for a fragile patient who wanted to live on. In the sense that the duties of medical professionals call for actions that are opposite to what common morality prohibits or allows, these species of ethics are clearly distinct from each other.

Logically, the same moral premises cannot lead to inconsistent conclusions in different sectors of human interaction. Either the conclusions in one domain are right, and the other wrong, or the domains are autonomous and the moral conclusions that they deliver are based on entirely different premises and justifications. Taken together, the counter-examples reveal that common morality should not be regarded as the ethics of medicine, and the profession's ethics must have a different foundation.

(2) By distinguishing professional duties from other social roles, my *positive argument* explains why the medical profession must have an ethics that is different from common morality. It is only because society allows professionals to employ *powers* and *privileges* that are forbidden to nonprofessionals, and because society grants professionals *immunities* from the penalties otherwise associated with such actions, that medical professionals are able to provide the services that society relies upon them to offer. In other words, the remarkable license granted to the profession by society enables society to reap the benefits that medicine can offer.

Society does not allow the distinctive powers, privileges, and immunities of professions to be employed by people outside of the profession because exercising them is inherently dangerous. And because people outside of the profession are barred from employing the exclusive powers and privileges of the profession, common morality has no rules or principles to guide their use. Professional ethics must

be constructed, on the one hand, to fill that void, and, on the other hand, to provide standards to assure society that the employment of the profession's unique set of permissions will not endanger the public.

Because professions can only exist when a society entrusts them to employ their distinctive license, professions create and publicly announce their distinctive creeds of ethics. "Seek trust and be deserving of it" and "Use the powers, privileges and immunities granted by society to serve the interests of individuals and society" are the two fundamental duties that professions share in common. The rest of the enumerated profession-specific duties are either derived from the profession's distinctive powers and privileges or they are necessary for addressing a profession's specific social responsibilities, its unique circumstances, and inimitable challenges. A profession's distinctive powers and privileges require uncommon limitations on how professionals employ their unique freedoms. To the extent that similar concerns arise in different professions, those professional groups will have similar uncommon duties.

Responding to My Critics

In this response to critics, I felt free to begin by summarizing my arguments for medical ethics being an uncommon morality because none of my critics responded to either of my arguments. James Childress and Tom Beauchamp find my position "shocking," "false," "dangerous," "highly questionable," "unrealistic," "a mishmash… that strains credulity," and "very odd." [13] Unfortunately, I missed seeing their arguments for those *ad hominum* conclusions that seem merely to reflect their presumptions. Ruth Macklin, who recognizes my arguments, brushes past them without grasping their implications.

Soren Holm[14] comes close to accepting the substance of both my negative and positive arguments. He acknowledges that even if medical ethics can be deduced directly from common morality, "there is no reason to think that it is easy or straightforward, or that we will always get it right."[15] He accepts the counter-examples of my negative argument, noting

> that there are many acts we allow or expect HCPs [health care professionals] to do which we do not allow or expect ordinary people to do, and that there are certain virtues we expect HCPs to possess and certain vices they must not possess where we do not have the same expectations of others.[16]

Holm also concedes that, "It looks like ME [medical ethics] is distinctly different from SCM [sociological common morality], and perhaps so different that it is not derivable and *sui generis*."[17]

Childress and Beauchamp[18] as well as Holm[19] go on to raise concerns about isolating medical ethics from societal input[20,21] and about my claim that the ethics of medicine "is constructed by medical professionals for medical professionals."[22] I suspect that our views on these matters are more aligned than they think. In light of the questions and confusion over these issues, I appreciate that I need to make a greater effort to explain my position and clarify my stand on these inter-related matters. In what follows, I attempt to clarify what I wrote before and thereby explain my views to these critics and other readers on how I understand the relationship of the medical profession to the society in which medicine is practiced.

Trust and Society

In explicating the ethics of medicine, I employ a concept of trust. As I use the term, I am referring to what philosopher Annette Baier has called "warranted trust."[23] I am also drawing on work by philosopher Onora O'Neill on the importance of trust and trustworthiness in the professions.[24,25,26] Most specifically, however, I am employing the concept as a critical element in political philosophy and relying on Thomas Hobbes's 1651 account in his hallmark work, *Leviathan*.[27]

There Hobbes explains a special kind of contract, which he called a "COVENANT or PACT," in which "one of the Contractors, may deliver the Thing contracted for on his part, and leave the other to

perform his part at some determinate time after, and in the meantime be trusted."[28] Hobbes, of course, is concerned with the covenant between the unity of the people that comprise Leviathan and the sovereign (a single legislator or a ruling body) who they authorize to represent them in ruling their society. In my analysis of this interaction, the people grant the sovereign extraordinary powers to create a currency, levy taxes, limit liberty, declare war, and so on. In their authorizing covenant, the people trust the sovereign to act in their interest by maintaining peace and enabling their society to continue flourishing in the future. Ultimately, however, the people maintain the power to define and redefine the powers of the sovereign, and the sovereign retains his distinctive powers and privileges only so long as he maintains the people's trust.[29]

Similarly, I maintain that the fundamental duty of the profession is to "Seek trust and be deserving of it." That core duty reminds professionals to focus attention on society's opinions of their professional behavior. Every license that the profession wields is contingent on society trusting that it is being employed for trustworthy goals and in a trustworthy manner. Earning society's trust for extending permission to new activities requires professionals to present reasons for being granted new permissions (e.g., to add "brain death" to the definition of death, to allow living donor organ transplantation, to permit assisted reproduction). Although advances in biomedical sciences and technological developments certainly play a role in expanding the permissions granted to the profession, the expansion of medicine's powers is also dependent on gaining society's trust every step of the way.

The profession must always be mindful of constraining advances so as not to outpace what society is prepared to tolerate (e.g., organ sales, germ-line genetic manipulation, and cloning). Arguments must be presented and a significant portion of the population must accept them before the profession is free to change its practice. To the extent that medicine is permitted to progress, the limits of social acceptance must be observed in order to maintain society's trust. Accepting the authority of society in granting the powers, privileges, and immunities of the medical profession makes the profession possible.

Holm misses my meaning when he ascribes to me the view that "we, as a matter of fact, allow the medical profession to decide the content of ME [medical ethics], *because* we trust the profession" (emphasis added).[30] In fact, Holms gets that point exactly backwards. I am arguing that the profession exists only *because* society grants the profession its distinctive powers, privileges, and immunities. Those grants last only so long as the profession uses them in a trustworthy way by serving the interests of patients and society: The profession survives only so long as it maintains society's trust, and that trust is fragile. The medical profession serves at the will of society, and the breadth and scope of the profession's powers, privileges, and immunities are whatever society says they are. In social contract terms, the profession has an "at will contract" that can be revised in any direction or cancelled at any time and for any reason, at the discretion of society.

Following Macklin's lead, a Covid-19 example may help clarify the position that I defend. Early on in the pandemic, most of us who were not trained in medicine did not understand the relevance or necessity of "flattening the curve," but medical professionals did. They had the expertise and experience to recognize that flattening the curve would be critically important for serving the interests of both individual patients and society. They therefore had the job of explaining the goal to the public and encouraging society to accept flattening the curve as social policy. Formulating the recommendations to wear masks and maintain social distancing comes from the profession, but professionals have the job of sharing the justifying rationale with society to gain social endorsement for their suggested policies.

Medicine as a Self-Regulating and Self-Policing Profession

A long recognized critical step in maintaining society's trust is the creation of the profession's distinctive ethics. Defining professional duties and setting professional standards allows society to trust that the allowed freedoms will be used well. The codes and oaths for medical professionals publicly declare the profession's commitment to society and make the standards for medical conduct transparently clear to the society in which it operates. Society accepts and expects the ethical standards of medicine to be

different from everyday ethics, so, in that sense, these two species of ethics coexist with very little tension between them.

Similarly, with the interests of patients and society in mind, medical professionals identify and define their professional duties. When medical professionals publicly declare the duties that society should expect them to uphold in an oath or by posting a professional code on a medical association website, they invite society to endorse and accept those standards as reasonable. Since at least the time of Hippocrates, that is how confidentiality, evidence-based practice, truthfulness, and the rest have come to be duties for medical professionals and why patients and society expect those commitments to be upheld, aside from extraordinary circumstance that society can accept as justifying exceptions.

Medical professionals have a privileged position for understanding the risks associated with wielding their powers and privileges. They also are able to comprehend what needs to be done to make effective use of their extraordinary liberties and the potential dangers of misusing them better than those outside the profession. Furthermore, their expertise, experience, and professional vantage point provide them with a unique perspective for evaluating professional behavior. I maintain that for these reasons, only medical professionals are adequately prepared to identify what the constraints on professional behavior must be. None of that however denies the relevance of social context or patient perspectives, which must always be paramount considerations.

Holm also misunderstands my claim about the autonomy of medical ethics. He seems to read me as claiming that medical ethics is more authoritative than common morality and that the two do not interact. Neither is the case. In fact, I clearly explain the sense in which I maintain that medical ethics is an autonomous field. Drawing on G.E. Moore and Bernard Baumrin, I defined a field as autonomous when its principles are not derived from another field. That account explains how two fields can be independent of each other. It does not assert any priority or authority of one over the other. If anything, because society sets the limits on professional powers and privileges, society has authority over professions.

Thoughts in Closing

Years ago, my son attended my colloquium presentation at a prominent university. An eminent philosopher from another university was in the audience. During the discussion period, she posed a challenging question. I was delighted that she had found my presentation worthy of her question, and thrilled that I had a ready answer. After the session, however, my son shared that he was furious with her for challenging me in that way. In pique, he remarked, "I thought she was your friend. She's had dinner at our house."

I had to explain that this is what philosophers do. We press hard in our search for the best answers we can come up with and we test each other's answers with tough questions to try to develop still better positions. Philosophy, including ethics and medical ethics, is built from theories that try to make sense of the world we experience. For the most part, we do not work with experiments that produce data that tests our hypotheses, we rely on thought experiments, distinctions, counter-examples, and arguments.

In that light, I am honored for the thoughtful comments from James Childress, Tom Beauchamp, Soren Holm, and Ruth Macklin and grateful to my fellow philosophers for sharing their criticism of my arguments for medical ethics as an uncommon morality. Their remarks have illuminated areas of my work that required further elaboration and clarification. I am also grateful to Tuija Takala, Matti Häyry, and Tomi Kushner for giving me this opportunity to publish my thoughts in this forum.

Notes

1. Rhodes R. *The Trusted Doctor: Medical Ethics and Professionalism*. New York: Oxford University Press; 2020.
2. Rhodes R. Why not common morality? *Journal of Medical Ethics* 2019;**45**(12):770–7.

3. Rhodes R. Medical ethics: Common or uncommon morality? *Cambridge Quarterly of Healthcare Ethics* 2020;**29**(3):404–20.
4. Rhodes R. In defense of uncommon morality: A Response to: Leonard Fleck, "Medical Ethics: A Distinctive Species of Ethics," Leslie Francis, "Beyond Common or Uncommon Morality" and Tuija Takala and Matti Häyry, "In Search of Medical Ethics and Its Foundation with Rosamond Rhodes," (CQ 29 (3)). *Cambridge Quarterly of Healthcare Ethics* 2022;**31**(1):144–149. https://doi.org/10.1017/S096318012100089X.
5. Here I am drawing on work by G.E. Moore and Bernard H. Baumrin that explains what makes a field of knowledge autonomous and distinct from other fields. Moore GE. *Ethics*. New York, NY: H. Holt; 1912; Baumrin BH. The autonomy of medical ethics: Medical science vs. medical practice. *Metaphilosophy* 1985;**16**(2&3):93–102.
6. Even though ordinary language extends the title "professional" broadly to include people who perform a task as their job, I am constricting the term based on my criteria. In my use of the designation, the title "profession" is ethically significant because it implies both *trust* and *fiduciary responsibilities*.
7. Fleck LM. Medical ethics: A distinctive species of ethics. *Cambridge Quarterly of Healthcare Ethics* 2020;**29**(3):421–5.
8. Macklin R. Another defense of common morality. *Cambridge Quarterly of Healthcare Ethics* 2022;**31**(2):177–84.
9. This diagram offers an overview of how common morality and professional ethics co-exist. The examples I offer are presented as an illustrative sample. I present no argument for the examples being a definitive complete list. Differences in the size of circles that represent various professions reflect no more than my limited ability in creating the Venn diagram. Neither the positioning nor the size of the circles is intended as a claim about their relative importance. I want only to indicate that there is some overlap in duties in some cases and not in others.
10. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*. 8th ed. New York: Oxford University Press; 2019, at 3.
11. See note 5, Beauchamp, Childress 2019, at 5.
12. In their article, Childress and Beauchamp maintain that neither Robert Baker nor I have adequately understood their position. I am happy to be in such good company.
    In spite of decades of sincerely trying to make sense of their largely accepted account of medical ethics, it still looks to me like an amalgam of Platonic realism, some version of virtue theory, a smidgen of Rawlsian constructivist reflective equilibrium, and bits and pieces of views that Beauchamp and Childress found appealing over time. I grant that I have been unable to discern the justification for the four principles or comprehend how the conglomerated additional elements fit together and interact. For those reasons, I am willing to accept Soren Holm's suggestion that my comments may address "sociological common morality" rather that Beauchamp and Childress's version of common morality.
13. Childress JF, Beauchamp TL. Common morality principles in biomedical ethics: Responses to critics. *Cambridge Quarterly of Healthcare Ethics* 2022;**31**(2):164–76.
14. Holm S. What is the foundation of medical ethics—Common morality, professional norms, or moral philosophy? *Cambridge Quarterly of Healthcare Ethics* 2022;**31**(2):192–98.
15. See note 14, Holm 2022.
16. See note 14, Holm 2022.
17. See note 14, Holm 2022.
18. See note 13, Childress and Beauchamp 2021, at 13–14.
19. See note 14, Holm 2021, at 6–7.
20. Francis raised similar questions. Francis L. Beyond common or uncommon morality. *Cambridge Quarterly of Healthcare Ethics* 2020;**29**(3):426–8.
21. Takala and Häyry also raised similar concerns. Takala T, Häyry M. In search of medical ethics and its foundation with Rosamond Rhodes. *Cambridge Quarterly of Healthcare Ethics* 2020;**29**(3):429–36.

22. See note 1, Rhodes 2020, at 345, 31, 40.
23. Baier A. Trust and antitrust. *Ethics* 1986;96(2):231–60.
24. O'Neill O. *Autonomy and Trust in Bioethics: The 2001 Gifford Lectures*. Cambridge: Cambridge University Press; 2002.
25. O'Neill O. Linking Trust to Trustworthiness. *International Journal of Philosophical Studies* 2018;**26** (2):293–300.
26. O'Neill O. *Justice, Trust and Accountability*. Cambridge: Cambridge University Press; 2005.
27. Hobbes, T. *The Clarendon Edition of the Works of Thomas Hobbes*, Malcolm N, ed. Oxford. UK: Oxford University Press; 2012.
28. See note 27, Hobbes 2012, at 204; 14, 11, 66.
29. Rhodes R. Hobbes's account of authorizing a sovereign. In: Adams M, ed. *A Companion to Hobbes*. Oxford, UK: Wiley-Blackwell; 2021, at 203–20.
30. See note 14, Holm 2022.

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