Commentary: Medical Ethics: A Distinctive Species of Ethics

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I share with Professor Rhodes the view that medical ethics should be thought of as a distinct species of ethics.[1] I have deliberately chosen the biological metaphor of a 'species' to better delineate the relationship between medical ethics and common morality. I believe our moral norms (understandings and commitments) have evolved over millennia in much the same way our scientific beliefs and norms have evolved over millennia. Emerging technologies (microscopes, enormous telescopes, particle accelerators), along with political, economic, and institutional change, have yielded a radically different understanding of reality from what 'common sense' took to be the case two hundred years ago. At the beginning of the 20th century we believed the entire universe consisted of just the Milky Way galaxy. In the middle of the 20th century the 'common sense' belief was that the earth's continents never moved. We could say that our scientific 'life form' has emerged over the past several hundred years from common perceptual experience enhanced by sophisticated scientific technologies. However, if we concluded from that, that science was merely a more complex version of common sense, our conclusion would be grossly inaccurate and misleading. Our sciences are distinct species of knowledge. They do not interbreed with common sense.

Common morality, like common sense, has evolved as well. Consider the acceptance of slavery, the denunciation of miscegenation, the abuse of women, and so on. Medical ethics, like science, might be seen as evolving out of common morality. Like the sciences, medical ethics has evolved with its own distinctive ethical norms and understandings as a result of emerging technologies (ICUs, organ transplantation, preimplantation genetic diagnosis, and so on) as well as changing political, economic, and organizational structures and practices relevant to health care. Common morality in itself has little of useful substance to offer regarding the ethics issues related to preimplantation genetic diagnosis as well as embryonic gene editing, and any number of other ethics issues related to reproductive medicine. Consequently, medical ethics should be seen as a distinct species of ethics, not capable of interbreeding with common morality.

Someone might care to argue that considerations of harm and benefit derived from common morality can be used to assess the ethical status of all manner of novel medical interventions. However, that would be at a very high (and useless) level of abstraction.[2] This would be analogous to someone arguing that science is just a version of common sense because scientists need to use their eyes to see the relevant scientific evidence. Scientific 'seeing' is radically different from common sense 'seeing,' which is why scientists can 'see' continental drift and climate change while common sense would never have the capacity to 'see' such phenomena. From both ethical and epistemological perspectives, the same can be said of medical ethics in relation to common morality, as I will show in the remainder of this commentary.

The sciences represent a distinct type of social practice with their own ethical and epistemic norms. If I hear a funny joke on the radio in the morning and I repeat it to

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my colleagues without informing them of the source of the joke, I am not open to some sort of ethical criticism. If a researcher is building on the scientific work of others and fails to acknowledge that formally and explicitly in the form of footnotes, that is regarded as a serious violation of scientific ethics. Medicine is also a distinct and complex social practice that has required its own ethical and epistemic norms that reflect the distinctive features of medicine as a practice. Common morality includes the belief that it is wrong to kill an innocent other. How should that bit of common morality apply to the emerging medical practices of physician aid-in-dying or voluntary euthanasia? Both practices involve causing the death of an innocent other. Is that just plain wrong, end of discussion?

I am not going to try to assess all the relevant ethical arguments brought to bear regarding those two practices. However, what is clearly relevant is that these practices have emerged as ethically viable alternatives to a 'natural death' because physicians have been able to forestall a natural death for many patients through multiple forms of aggressive life-prolonging care (mostly endorsed and sought by patients). In many cases, however, that will mean this alternative death will involve more suffering than would otherwise have been the case if there had not been that life-prolonging medical intervention. It would hardly be ethically commendable for a physician to walk away from a patient at that point after saying, "I saved you from a 'premature' death three years ago and made it possible for you to achieve your 85th birthday. These are just the consequences of my best efforts to prolong your life. You made that choice (stop being a baby)."

It would, however, be equally criticizable if the physician in that same scenario had said to that patient at age 82 with end-stage kidney failure, "There is nothing more I can do. You have had a good life. Your kidneys are failing. Please accept your death with dignity and grace." This physician would not have the option of refusing to offer dialysis to this patient, especially if the patient were otherwise in reasonably good health. The point is that physicians are in these circumstances because they have at their disposal all of the life-prolonging technologies that have entered medicine for the past fifty years. This generates ethical responsibilities regarding the fate of these patients that are never part of the lives of nonphysicians and common morality. These are challenges that have to be addressed and justified within medical ethics.

It is noteworthy that virtually all the different sorts of health professionals have their own published codes of ethics. The *Code of Medical Ethics* from the American Medical Association Council on Ethical and Judicial Affairs runs for well over 200 pages. It is hard to imagine why such length would be necessary if medical ethics were largely just an applied version of common morality (which does not seem to have any published form, contrary to what Gert, Clouser, and Culver seem to claim).[3] Nurses, psychologists, social workers, physical therapists, physician assistants, among others, all have their own codes of ethics. These codes are all seen as being versions of the same 'species' of ethics. What represents the common element among these codes is that they are about the ethical obligations health professionals have to *patients*.

What must be emphasized is that patients are not simply persons with an illness, analogous to a person with a tie or a person with a bracelet. Illness, of any significant consequence that requires physician expertise, is transformative of a person. Such an illness makes a person a *patient*: fearful, anxious, dependent, threatened, apprehensive, vulnerable, ignorant of what might threaten their very existence. Patients

require the skills and expertise of physicians or other health professionals. As Professor Rhodes points out, patients need to be able to trust health professionals without reservation. Those codes of ethics provide the reasons why patients should be able to trust health professionals as they assess and seek to repair our bodies and our minds. These are not the sort of relationships we have with one another in our everyday healthy lives. Common morality is perfectly adequate for governing those relationships.

We live in an extraordinarily complex world in terms of social institutions and practices, and corresponding social relationships. For that reason, multiple species of professional ethics exist (and need to exist). These different species may appropriate simpler, more primitive ethical commitments from common morality (as does medicine), but those commitments and understandings are substantially transformed and complexified by that more complex institutional environment (just as the DNA of all manner of primitive species has been incorporated into human DNA). Journalistic ethics are not legal ethics are not business ethics are not medical ethics. Consider for a moment that businesses are expected to compete with one another, with the goal of economic efficiency and technological innovation being seen as significant social goods. Businesses aim to drive their competitors out of business. An oft-heard motto is "Economic construction requires economic destruction." That destruction means the loss of jobs, family income, physical and psychological suffering, and multiple kinds of social disruption. Yet none of these obvious harms (from the perspective of common morality) are condemned as unethical within the context of business ethics (assuming no violation of the rules of fair competition). A similar situation obtains in the realm of legal ethics where an attorney is expected to defend vigorously a client accused of some heinous crime, even though the attorney knows his client is guilty of committing that crime. Again, it would be ludicrous to simply see such a practice as a variation of common morality, or, in some way justified through some connection with common morality.

In concluding this commentary, I want to address some recent criticisms directed at Professor Rhodes' main contention. She sees herself as rejecting the views of Beauchamp and Childress,[4] as well as Gert, Clouser, and Culver, that see common morality as being the ethical foundation (with something of a justificatory role) in relation to medical ethics as well as other forms of professional ethics. At one point she writes, "I finally reached the conclusion that common morality and medical ethics were incompatible."[5] Bryanna Moore objects to the claim that medical ethics and common morality are "incompatible" with one another.[6] That term can be interpreted in a number of ways. Fire and water are incompatible with one another; one will destroy the other. Biological species are incompatible because they cannot interbreed, but they are able to live peacefully with one another, perhaps sharing some traits in common. This latter interpretation seems closer to what Professor Rhodes has in mind.

Beauchamp and Childress describe common morality as being "universal."[7] Many anthropologists would challenge the truth of that claim. However, we can ignore that challenge. A charitable reading of that claim would be that no society of any complexity could survive if murder, stealing, rape, and lying were widely accepted practices. That obviously applies to medicine as well. Physicians may not murder, steal from, rape, or routinely lie to their patients. Medicine as a practice would be impossible under those circumstances. However, that does not mean that the whole of medical ethics is just an elaboration of the tenets of common morality,

any more than our contemporary sciences are just an elaboration of common sense experience. Nor does it mean that common morality provides the ultimate justification for the rules and precepts of medical ethics, though Beauchamp and Childress write, "We have argued that justification [in medical ethics] requires considered judgments drawn from the common morality."[8] No doubt, some considered judgments from common morality are part of medical ethics, but the practice as a whole has a distinct focus (patients, as described above) and a degree of complexity that far exceeds the capacity of common morality to analyze adequately or to justify.

Foster and Macklin[9] seek to undercut Professor Rhodes' central claim by claiming that the examples she gives of ethical commitments distinctive of medicine are in fact part of common morality as well. Rhodes calls attention to the requirements of confidentiality as an integral ethical commitment in medicine. Foster responds that "there is nothing at all unique about medical confidentiality." This is too simplistic a response. In ordinary life we have all sorts of little behavioral rituals we use to convey an expectation of confidentiality. In medical practice the expectation of confidentiality is ubiquitous. Unless a patient gives explicit permission to share her information outside the circle of caregivers directly involved with her care, nothing can be legitimately shared. This is not just a quantitative difference; this is a practice directly tied to the rights of patients as patients who must often reveal intimate and shameful details about themselves in order to be assured of getting appropriate medical care.

Foster writes: "Physicians have distinctive technical skills, but technology should not drive morality. Medicine should not be an island, unconnected morally to the rest of the world, to which separate rules apply…. Rhodes' contentions are not only wrong: they are dangerous."[10] I am unclear regarding what Foster is asserting about technology driving morality. This sounds like a prescriptive ethical claim. What should that mean? What is clear and indisputable is the factual claim that new medical technologies often generate novel moral challenges that involve pitting settled ethical commitments against one another. Should we give up our capacity to do major organ transplantation, provide ICU care, offer preimplantation genetic diagnosis, or treat HIV with triple-drug combinations so that the ethical equilibrium that may have existed in medicine in 1960 remains undisturbed? This is a rhetorical question which I assume no rational or reasonable person would answer affirmatively. All of these technologies disrupted, for a time, a local ethical equilibrium within the broader field of medical ethics. These disruptions are not intrinsically ethically objectionable. These are not instances of Nazi medicine. Nor do we take organs from prisoners to save the lives of more righteous citizens in end-stage organ failure. But we do struggle with the question of whether we should do seven-organ transplants to save one life (as in the case of intestinal transplants) when we might have saved three or four other lives if we had disaggregated those organs. The fact that we struggle with such issues in medicine is indicative of ethical sensitivity, not ethical danger.

Medical ethics is not an intellectual ethical island, as Foster fears. As noted earlier, it is better thought of as an ethical species that must have ecological connections with many other species of ethics, including common morality, as part of an overall ethical environment. This is what John Rawls would refer to as "wide reflective equilibrium."[11] This is a reasonable view, as defended by Professor Rhodes.

Notes

1. Rhodes R. Medical ethics: Common or uncommon morality. *Cambridge Quarterly of Healthcare Ethics* 2020; 29(3):404–20.
2. Charles Foster seems to take this view. He dismisses all the concrete examples of distinctive features of medical ethics offered by Rhodes as just more elaborate examples of common morality. His conclusion in this regard is, "We're back to justification on the basis of doing good or avoiding harm." Foster C. Doctors should be morally common: A reply to Rosamond Rhodes. *Journal of Medical Ethics* 2019 (in press). Doi: 10.1136/medethics-2019-105878.
3. Gert B, Clouser KD, Culver CM. *Bioethics: A Return to Fundamentals.* New York: Oxford University Press; 1997.
4. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*, 7th ed. New York: Oxford University Press; 2013.
5. See note 1, Rhodes 2020.
6. Moore B. Why Only common morality? *Journal of Medical Ethics* 2019 (in press). Doi: 10.1136/medethics-2019-105840.
7. See note 4, Beauchamp, Childress 2013, at 410–1.
8. See note 4, Beauchamp, Childress 2013, at 410.
9. Macklin R. Common morality and medical ethics: Not so different after all. *Journal of Medical Ethics* 2019 (in press). Doi: 10.1136/medethics-2019-105825.
10. See note 2, Foster 2019.
11. Rawls J. *A Theory of Justice.* Cambridge, MA: Harvard University Press; 1971:48–53.