Commentary

Commentary: In Search of Medical Ethics and Its Foundation with Rosamond Rhodes

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Introduction

In her thorough and thoughtful contribution to the *Cambridge Quarterly of Healthcare Ethics* titled "Medical Ethics: Common or Uncommon Morality" Rosamond Rhodes argues that contrary to American mainstream bioethics, medical ethics is not, and should not be, based on common morality, but rather, that the medical profession requires its own distinctive morality.[1] She goes on to list sixteen duties that, according to her, form the core of medical ethics proper.

While we find Professor Rhodes' article enlightening and intriguing, there are three main points we would like to raise. The first of these we do not direct against Professor Rhodes alone, but rather against anyone who relies on the notion of 'a common morality.' We shall briefly explain why we find this idea unhelpful, both in the field of medical ethics and in morality and politics more widely. For our second point, we shall assume, for argument's sake, that some kind of a 'common morality' does exist, and show how Professor Rhodes, for various reasons, fails to convince us that medical ethics needs to be kept separate from it. As our third point, we shall show that even if one thought that Professor Rhodes' idea of an exclusive medical ethics is warranted, her list of duties specific to the medical profession is far from obvious and definitely needs further justification and, most likely, some revision.

For the record, this is not the first time we are exchanging views with Professor Rhodes in bioethics journals.[2,3] Given our overall outlook, in some senses more liberal and in others more utilitarian than hers, it is not surprising that our views collide with Professor Rhodes' more paternalistic and more Kantian approach. This is especially apparent when the concept of autonomy is under scrutiny.

No Such Thing as a Common Morality

When the academic discipline of bioethics began to take shape, many of its pioneers were theologians and philosophers.[4,5] Those pioneers brought to the table, among other things, the main ethical theories of their time, outcome-oriented utilitarianism and duty-and-right-focused Kantian thinking.[6,7] The doctrines are visible in *The Belmont Report*,[8] probably the most influential official document on bioethics in the United States. They also formed the original basis of Tom Beauchamp and James Childress's globally influential four principles doctrine.[9,10,11] Beauchamp worked on the Belmont Report and his book with Childress simultaneously,[12] and the foundational similarities are clearly visible. The

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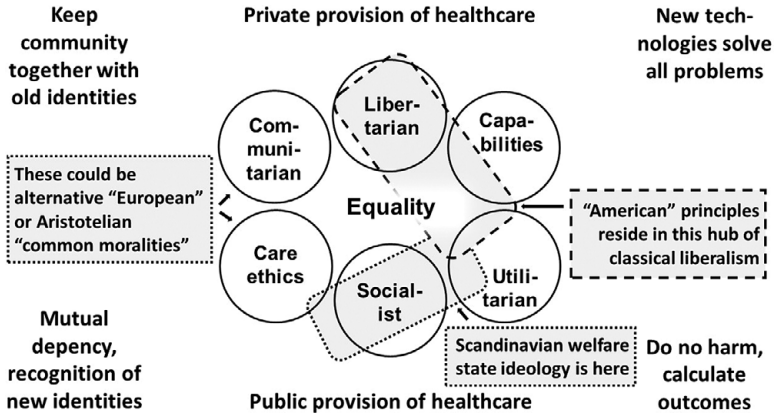

Figure 1. The locations of some main bioethics 'common moralities' on a map of justice.

combination of outcome- and duty-based moral thinking is also detectable in Bernard Gert, Charles Culver, and K. Danner Clouser's list of medical commandments.[13,14] There are, however, other ethical approaches, notably Aristotelian and feminist, and their advocates have made their views audible since the dawn of the discipline.[15,16,17,18,19] It seems that the pressures caused by these other approaches guided some of the early champions of bioethical principlism to switch to the language of 'a common morality.'[20,21] Instead of saying, "There are these two great theories that account for all our moral thinking," they could now say, "We rely on Common Morality, which is shared by all rational and reasonable people." The only break from this that we see in Professor Rhodes and her list of duties is the insertion of "all rational and reasonable medical professionals" in place of "people." The root, a combination of utilitarian and Kantian thinking, seems to remain the same, despite her efforts to introduce Aristotelian or Aristotelian-like elements into the picture. A map of justice that we have introduced and applied in our previous work demonstrates the situation.

Ethical theories and political moralities follow a simple overall logic, and they fall into six main categories according to their takes on three divisions, those between the private and public ownership of the means of production, the universal or positional nature of ethical and political norms and values, and an emphasis on spontaneously formed tradition or calculable wellbeing. The extremes in this constellation are libertarianism and socialism (private/public), liberal thinking and care ethics (universal/positional), and communitarianism and utilitarianism (tradition/general wellbeing). Views on bioethics, and the 'common moralities' or rationalities[22] that go with them fall nicely into the map that presents these dimensions,[23,24,25] as illustrated in Figure 1.

All 'American' bioethical rationalities fall squarely on the libertarian-liberal-utilitarian side of the map. Their sense of autonomy is mostly libertarian-liberal, their sense of avoiding harm and doing good in the roughly utilitarian corner, and their sense of justice vaguely somewhere in between. This is in contrast with the socialist-utilitarian welfare-state model that places more value on public good produced by public measures;[26] with the care-socialist approach that prefers special relationships and recognized interdependencies to ideals of individual freedom;

and with the 'European' values of thick autonomy, solidarity, precaution, and subsidiarity. We have explained these in more detail elsewhere.[27,28]

The manner in which Professor Rhodes approaches ethics in general defines her initial theoretical position. Public morality is about public good, and individual morality is about doing what you want as long as you do not harm others. This is a distinctly liberal and utilitarian way of thinking, and we have no quarrel with it, but it is more or less alien to the remaining, more collectivist doctrines—or alternative 'common moralities' or rationalities—on the map. As a definition of common morality, it opens up the opportunity to search for the duties of the medical profession among the other ideologies. Care ethics would be a good candidate, and a thorough empirical investigation of spontaneously formed practices in medicine could show what people in the field do. These are not, however, directions that Professor Rhodes primarily explores. Instead, she presents a comprehensive list of duties that is more or less compatible with earlier principlist efforts to apply the four principles or the ten commandments to medical contexts.

Common Morality Assumed

In an attempt to show that medical ethics is distinct from common morality, Professor Rhodes gives us seven examples of situations where the two seem to yield different moral decisions. She reminds us that according to logic, only one example disproving common morality's universal claim, would be enough.[29] We do not think that she necessarily succeeds in showing this to be the case.

Four of the examples are not exclusively applicable to medical professionals. The presumption of confidentiality (3) applies also to lawyers and clergy, and arguably to close friendships. People can also expect that governmental bodies and the law treat them equally and in a nonjudgmental manner (4). Sexual relationships, forbidden between medical professionals and their clients (5), are also frowned upon between siblings, teachers and students, and co-workers in many workplaces. Police officers and insurance companies can ask very personal questions that should be answered truthfully (6).

The three remaining ones are problematic in a different way. It seems that Professor Rhodes has written more than what is warranted into the examples. One (2) says that in everyday life we are allowed to make choices based on whatever we like (horoscopes or flipping a coin), but medical professionals need to base their decisions on scientific evidence. There are two problems with this. First, in everyday life, we may not make decisions concerning others based on our own likings. Most 'common moralities' do not allow harm to others, and medical ethics is about dealing with other people. Conversely, medical professionals can, just like anyone else, make self-regarding personal choices based on a throw of dice, if they so choose. Secondly, medical professionals often need to make educated guesses or even base their recommendations on gut feelings. In many medical situations, the scientific evidence is not conclusive.

Another example (7) states that morality in ordinary life requires us to regard other adults as autonomous, but that physicians should not presume that their patients are acting autonomously when they appear to make poor health choices. "Instead they are responsible for vigilant assessment of patients' decisional capacity, and sometimes required to oppose patients' stated preferences."[30] We do not fully agree with this. The wording is too strong. A presumption of autonomy must

be a starting point for medical professionals (perhaps even more so than for lay people in everyday life situations), due to the uneven power relationship between them and their patients. Further, as Professor Rhodes argues (more on this below) that the medical professionals' most important duty is to "[s]eek trust and be deserving of it," surely she must understand that this cannot be achieved, if the presumption is that the patient who does not readily agree with the medical professional is nonautonomous. We at least would think twice before putting our health and lives in the hands of physicians whose default idea is to override our wishes as soon as they differ from theirs.

Rhodes' first example (1) is possibly the most puzzling of them all.

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

This seems to imply that physicians are saint-like creatures who always put medical needs first. Yet there is an incalculable amount of unmet medical need everywhere in the world, and if this were to be taken in any way literally, medical professionals should never have a day off or a vacation. The presupposition of a positive duty to respond to patient need is a wonderful ideal but in reality, is simply too demanding and needs to be qualified. It is also worth noting that when summoned by fellow physicians to partake in voluntary work with the poor, undocumented, or other people without access to medical care, there is no empirical evidence that all medical professionals would rush to help. Whatever Professor Rhodes means by this example must be much narrower in scope than what it actually says.

Later on in the paper, she provides us with a one more example of how, allegedly, medical ethics differs from 'common morality.' She asks us to consider a case where a person falls on a cracked pavement, seems to have injured her knee, and wants to sue for damages. She could greatly benefit from a successful claim. However, the examining doctor finds out that the injuries to her knee are due to osteoarthritis and not a result of the fall. Professor Rhodes goes on to claim that for common morality, this situation would present a dilemma, but not from the viewpoint of medical ethics, as the doctor needs to tell the truth.[31] We would assume that 'common morality' would reach the same conclusion. There is no dilemma within 'common morality' here, as lying is not condoned in any of its incarnations.

Professor Rhodes concedes that the 'mainstream bioethicists' she criticizes—Tom Beauchamp, James Childress, Bernard Gert, Daniel Clouser, Charles Culvert, Albert Jonsen, Mark Siegler, and William Winslade—do acknowledge that, in addition to common morality, professionals have special moral obligations that arise from their profession (different professionals have different duties, like the occupants of different roles have different obligations), but she claims that they fail to explain what those commitments are, how they come about, and what the specific obligations are. Unfortunately for her own narrative, Professor Rhodes does not seem to do much better. She gives a list of duties (which we will turn into in the next section) and says that their source is an overlapping consensus of rational and reasonable

medical professionals. We are not certain that the list that she comes up with is, indeed, reflective of "what the rational and reasonable medical professionals would agree upon,"[32] and even if this were the case, what would make it 'medical ethics' as it should be. What would give it its legitimacy?

In giving reasons as to why medical ethics is separate from common morality, Professor Rhodes explicitly states that "[d]ecisions about matters of medical ethics need not to be endorsed by the general public or individuals outside of the profession"[33] and states elsewhere that, "[b]ecause medical ethics is radically different from common morality, it has to be inculcated and policed by the profession."[34] However, given that the most important duty she bestows upon the profession is to "[s]eek trust and be deserving of it,"[35] it very much seems that the general public must be happy with the ethical code that the profession upholds. Therefore, while the medical profession might have duties (and privileges) different from the general public, it seems that, in the end, Professor Rhodes' own model is not that far removed from the 'common morality' approach.

The Limits of Rhodes' Medical Ethics

Professor Rhodes states:

> 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 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.[36]

The list of specific duties comprises of: (3) develop and maintain professional competence; (4) provide care based on need; (5) be mindful in responding to medical need; (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; and (16) assure justice in the allocation of medical resources.[37] It is somewhat unclear whether these are listed in a hierarchical order, but given that she has numbered them and they follow the above-mentioned foundational duties, we think one can assume that this is the case. Let us, however, start from the beginning.

As noted in the previous section, medical professionals will have difficulties in gaining trust if people do not agree with their ethical code. We would assume that the acceptability of the code is an important element in establishing trustworthiness. Unlike Professor Rhodes seems to think, in this sense, the ethics of medicine cannot be internal to the profession.

The second fundamental principle, according to which medical professionals must use their professional abilities *only* to advance the interests of patients *and* society, seems problematic at least in four ways. First, we do not think that too many medical professionals would agree to do their job *only* to advance the interests of

their patients and society. This would be supererogatory beyond reason. Second, to require medical professionals to act in the interest of society (however defined) is to ask them to do something that they are not qualified to do. What is and what is not in the interest of a society is not something that medical expertise qualifies one to assess. (There is a similar problem with duty 16, which obliges the medical professionals to assure justice in the allocation of medical resources. This is also beyond their competence, not to mention their powers. There cannot be a duty that one is unable to fulfil.) Third, it is unclear what exactly 'interest' is supposed to mean here. If the medical profession has a duty to advance patients' interests beyond medical needs or health, respect for autonomy should be integral to this duty or, at the very least, not all the way down to the tenth place on the list. Fourth, and perhaps most problematically, this duty has an inbuilt discrepancy. The interest of the patient is often in conflict with the interest of society. One of the reasons why Professor Rhodes criticizes the 'common morality' models is that they include principles or duties that can conflict with one another. It is arguably even more problematic when a foundational duty has a conflict built into it.

It looks like there is some overlap with the remaining duties. Their order raises some questions and with some it is unclear (based on this article) what Professor Rhodes thinks they mean. Here are some examples. If medical professionals are duty-bound to provide care based on need (4), one would assume that being responsive to requests from peers (13) would already be included. For us, it is also unclear why "maintain nonjudgmental regard towards patients" (7) and "maintain nonsexual regard toward patients" (8) come before "respect the autonomy of patients" (10). One would think that respecting autonomy would be a more fundamental principle. Of the other duties, the exact meaning of, for instance, "be mindful in responding to medical needs" (5) escapes us. It seems that it somehow qualifies "provide care based on need" (4) and perhaps "base clinical decisions on scientific evidence" (6); although it precedes the latter. How it further defines these remains unclear. Moreover, as indicated before, the "duty to base clinical decisions on scientific evidence" (6) is also problematic in the sense that sometimes there simply is not enough scientific evidence, or the evidence available is inconclusive.

Conclusions

Professor Rhodes' new medical ethics is an ambitious undertaking, and while a fresh approach to the ethics of medicine is indeed welcome, it seems that her model suffers from many of the same problems as the theories she criticizes, and that she has actually added a few new ones. Granted, however, that in the conclusions section of her article, Professor Rhodes writes that "the specific duties and virtues that constitute medical ethics still need to be more fully articulated, justified, and illustrated with examples that help medical professionals understand their professional obligations and how they may be fulfilled,"[38] and perhaps some more clarity can be expected once her book on the topic becomes available.[39]

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33. See note 1, Rhodes 2020, at 405.
34. See note 1, Rhodes 2020, at 415.
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