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ARTICLE

Another Defense of Common Morality

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Abstract
Robert Baker and Rosamond Rhodes each argue against the universality "common morality," the approach to ethics that comprises four fundamental principles and their application in various settings. Baker contends that common morality cannot account for cultural diversity in the world and claims that a human rights approach is superior in the context of global health. Rhodes maintains that bioethics is not reducible to common morality because medical professionals have special privileges and responsibilities that people lack in everyday life. Baker fails to demonstrate how the human rights approach to global ethics is more sensitive to culture than the use of bioethics principles that comprise common morality. Rhodes has a narrow interpretation of "common morality," which when understood more broadly, accounts for the special privileges and obligation of medical professionals.

Keywords: common morality; human rights; global ethics; medical professionals

Let me begin by acknowledging my respect for the work of Bob Baker and Rosamond Rhodes, despite my critique of their recent writings in this paper. The critique focuses on the central points in two articles. The first is Baker's contention that human rights provide a basis for a globally recognized discourse and standard of morality, whereas an appeal to fundamental ethical principles cannot do so.[1] The second is Rhodes's view that bioethics is not reducible to the position known as "common morality,"[2] as explained and defended by Tom Beauchamp and Jim Childress in their seminal work, *Principles of Biomedical Ethics*.[3] In this paper, I refer to a commentary I wrote[4] in response to an earlier article by Rhodes,[5] but I do not rehash the arguments in detail. My comments on Baker's position refer to his brief commentary in a book published in 2020.[6] Following my defense of common morality in reply to Rhodes and Baker, I end with an illustration of the global application of common morality in the debates surrounding contentious issues in the COVID-19 pandemic.

To set the stage, I note that this is a controversy destined never to end. Is there a universal morality? Or are there only particular moralities? Are ethical principles relative to time, place, and culture? Or are they applicable to the myriad circumstances in which people behave the world over? Do human rights provide a better moral standard than "common morality," understood here as the well-known "four principles" elaborated by Beauchamp and Childress? Does medical ethics have a particular morality, one that is distinct from "common morality," as Rhodes argues? More than 20 years ago, I devoted an entire book to the topic of ethical relativism on a global scale.[7] The effort in this short essay is distinctly more modest. My main points are the following: (1) both human rights and common morality are examples of ideal approaches to a universal conception of ethics; (2) human rights are neither more nor less "ideal" than the precepts of common morality; (3) specific provisions in human rights declarations and treaties embody the same moral principles that constitute common morality; (4) medical ethics, construed as the rights, privileges, and obligations of doctors and other health professionals is only one example among many of role responsibilities and privileges that human beings have in their jobs, their families, their social lives, and as citizens.

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Baker's Defense of a Human Rights Approach

Baker rejects the view that common morality is universal morality. He criticizes the position defended by Beauchamp and Childress that common morality is not relative to culture or individuals. The well-known, four "clusters of moral principles" are: respect for autonomy, nonmaleficence, beneficence, and justice. Baker rejects this construction and instead, defends a human rights approach that, in his words, is "a globally recognized discourse and standard of morality that all member states of the United Nations are committed to respecting."[8] It is true that a majority of member states have signed and ratified the various treaties. But is that sufficient to constitute respect? "Respect" is a concept to which anyone can pay lip service. More appropriate is the language found in human rights treaties that require states parties to "respect, protect, and fulfill" the provisions in those treaties. Some (if not many) countries are in constant violation of specific provisions of those treaties, whereas other countries violate them on a few occasions or in certain circumstances. Let's look at a few brief examples.

CEDAW (Convention on the Elimination of All Forms of Discrimination Against Women)[9] stipulates the rights of women that countries should respect, protect, and fulfil. By law or custom, some countries or religious groups within several countries place restrictions on women's freedom of movement and self-determination. Saudi Arabia (one of the more extreme examples) prohibits women from doing certain things without permission from their husbands or fathers. Examples include applying for passports, traveling abroad, getting married, opening a bank account, and getting elective surgery. Only since 2018 did the country abandon a law that prohibited women from driving cars.

The *International Convention on the Elimination of All Forms of Racial Discrimination*[10] is systematically violated by China's treatment of the Uyghers, a Muslim minority now largely confined in internment camps and subject to other restrictions. Families in this group are now being prevented from having more than one child by forcible sterilization of women or imposing unwanted contraception on them. Another example is Myanmar's treatment of the Rohingya minority (also Muslims). The government has engaged in torture, unlawful arrest and detention, restricting movement, placing limits on religious practice, and discrimination in employment and access to social services.

The *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*[11] is systematically violated in a number of countries. That includes the United States in its torture of captives following the 9/11 attack. Then-president George W. Bush and members of his administration openly supported practices, such as water-boarding, and openly defended them. Arguably, the United States is in violation of the *Convention on the Rights of the Child*12 in its ongoing treatment of unaccompanied minors who cross the border and are kept in overcrowded detention camps in unhygienic conditions.

Baker says: "the possibility of a culturally independent set of universal standards 'not relative to culture' is merely wishful thinking."[13] It is not clear how Baker's defense of human rights squares with this statement. It is, of course, true that United Nations' member states are presumably committed to upholding the rights articulated in its numerous treaties and declarations. That alleged commitment is implied by the countries having signed and ratified the various treaties. Many cultural practices are unrelated to moral behavior and therefore not subject to compliance with the rights articulated in human rights treaties. Examples are the restrictive dietary laws of Orthodox Jews and Muslims and various rituals in the observance of holidays. Other cultural practices are in direct violation of human rights instruments. Examples include female genital cutting (a morally neutral term for what is typically referred to as "genital mutilation"), and the practices still observed in some Muslim countries of cutting off the hands of thieves and stoning to death people who have committed adultery (usually women in those cases). The precepts of common morality are just as robust in their moral condemnation of such cultural practices as are the human rights articulated in the *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.*

It is not clear how the above-noted examples of obvious human rights obligations square with Baker's claim that "Rights-based bioethics can thus provide a common starting point for developing a form of global bioethics that is sensitive to cultural and society diversity."[14] Many people within the countries where such violations of human rights occur condemn the cultural practice that condones them. Simply

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put, there is no effective enforcement mechanism for the various human rights treaties in countries that violate them with impunity. It is also unclear how the human rights approach to global ethics is more sensitive to culture than the use of bioethics principles that comprise common morality.

As an example of cultural differences that exist even in Western democracies, Baker cites the concept of solidarity, which appears in the 2005 UNESCO *Declaration on Bioethics and Human Rights.* Baker refers to "the robust moral concept of 'solidarity'" found among continental Europeans, and he says that concept is "notably absent from Anglo-American discussions of bioethics and moral philosophy."[15] Since Baker wrote those words, it would appear that solidarity is rapidly crumbling. Western European countries have rejected immigrants from numerous countries and prevented boats laden with African refugees from landing on their shores; the "Yellow Vest" anti-government protests began in France in 2018 and continue today; and far-right, anti-Semite, and anti-Muslim sentiments and actions have become stronger and more widespread in France and Germany, two leading Western European democracies. So much for solidarity in Western European countries today.

It is ironic that Baker cites the UNESCO Declaration on Bioethics and Human Rights as a point in favor of his position and against that of common morality. Article 4 of the Declaration is entitled "Benefit and Harm." It says: "In applying and advancing scientific knowledge, medical practice and associated technologies, direct and indirect benefits to patients, research participants, and other affected individuals should be maximized and any possible harm to such individuals should be minimized."[16] This is none other than the *principle of beneficence*, one of the four pillars of common morality. Article 5 is entitled Autonomy and Individual Responsibility. It says: "The autonomy of persons to make decisions, while taking responsibility for those decisions and respecting the autonomy of others, is to be respected. For persons who are not capable of exercising autonomy, special measures are to be taken to protect their rights and interests." This human rights statement is clearly *respect for autonomy*, another pillar of common morality.[17]

Article 12 of the UNESCO Declaration is entitled Respect for Cultural Diversity and Pluralism. Here, we should be able to see how a human rights approach is superior to common morality in addressing cultural differences. But the article says: "The importance of cultural diversity and pluralism should be given due regard. However, such considerations are not to be invoked to infringe upon human dignity, human rights, and fundamental freedoms, nor upon the principles set out in this Declaration, nor to limit their scope."[18] This article acknowledges the existence and importance of cultural diversity yet affirms the universality of human rights that may override cultural practices that violate the precepts articulated in the right in question.

United Nations declarations and treaties primarily address the obligations of nation states rather than individual actors, whereas the principles embodied in common morality apply to both governmental and human actors. Neither human rights nor common morality has the force of law in places where there are clear violations of the articles or principles. Yet both approaches enable sanctions of various sorts when violations occur. The two approaches to morality are compatible and mutually reinforcing.

Rhodes on Medical Ethics, Bioethics, and Common Morality

Like Baker, Rhodes is critical of common morality and its use of the four principles. But whereas Baker argues that human rights provide a better approach to ethical concerns in a global context, Rhodes contends that common morality cannot account for the special circumstances in medical ethics. Referring to her earlier article on this topic,[19] she says: "My paper presented two arguments for concluding that common morality is untenable as an account of medical ethics. First, I provided a negative argument to show that common morality does not provide an adequate account of medical ethics. Second, I offered a positive argument that demonstrated why the medical professions require a distinct morality."[20] As noted above, I was one of several authors who commented on Rhodes's paper.[21] I replied to each of seven examples Rhodes used in defense of her position that the special concerns of medical ethics involve obligations and responsibilities that differ from those people face in ordinary life. I concluded my disagreement by saying: "Ordinary life contains myriad examples of behaviors that are

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ethically acceptable or required in some contexts and prohibited in others. In this respect, the ethics of medicine is not 'distinct and different from common morality,' Rhodes's main contention."[22]

I focus first on Rhodes's negative argument. She replies to one of the points in my critique of the main thesis in her earlier article. There Rhodes maintained that standardly accepted behavior for medical professions and others differ, and departures from those standards require justification. One example involves preserving confidentiality. Rhodes says that "freely sharing information is standardly allowed in common morality," whereas "upholding confidentiality is the ethical standard for medical professionals."[23] Rhodes and I agree that both situations allow for justifiable exceptions from the norm. She says it is "a telling distinction because it shows that the presumed standard for professional conduct is starkly different from the standard in everyday life."[24] I agreed with the point that justification is required for departures from standards; but I said it simply depends on where the presumptions lie.

I believe the difference between Rhodes's view and mine lies in our respective interpretation of common morality. Rhodes's interpretation appears to be something like the following. "Common situations *in ordinary life* [my italics] permit or prohibit certain behaviors. That constitutes 'common morality' in that sphere of behavior. Many situations in the work of medical professionals call for restrictions or permissions in that sphere of behavior, different from those in ordinary life. The required behavior of medical professionals departs from the presumptions regarding such behavior in ordinary life and is therefore different from 'common morality'." In contrast, I hold that common morality incorporates both the medical profession's adherence to confidentiality and the everyday situations in which confidentiality is not ethically required. Here is my alternative to Rhodes's interpretation: "Various situations permit or prohibit certain behaviors, depending on the circumstances. The nature of those circumstances determines whether the presumption lies in permitting or prohibiting those behaviors. Common morality applies to the range of situations and circumstances, including ordinary life, business and government, the behavior of professionals, and other contexts." Of course, this statement of common morality is very general and requires elaboration in specific contexts. This is how it applies to the example of confidentiality. As Rhodes acknowledges in her article, freely sharing information is generally allowed among friends and colleagues, unless one person elicits a promise from another not to reveal what she has just been told. In contrast, in the medical and legal professions, the doctor or lawyer is ethically required to preserve the confidentially of the patient's or client's information. However, that usual requirement may be overridden when the law requires physicians to disclose certain information, such as a patient's stated intention to cause immediate harm to others. In some cases, a judge may require an attorney to disclose confidential aspects of a case typically protected by attorney–client privilege. Although the general presumption regarding confidentiality varies according to the circumstances, common morality embodies both ends of the spectrum, as well as an uncertain middle ground.

According to my understanding of the concept, "common morality" does not have a narrow scope, meaning only what it is permissible and required for "ordinary people" in the course of their "everyday lives." Rather, it refers to the entire range of behavior of people in their various circumstances. This brings me to Rhodes's positive argument, where she makes a distinction between roles and professions. She says: "societies allow professionals to employ powers and privileges that are not allowed to anyone else."[25] According to this distinction, Rhodes presumably holds that firefighting is not a profession. But as an integral part of their work, firefighters are permitted to smash the doors and windows of a burning building and pick up a child and carry it to safety. Firefighters are also required to engage in behaviors that would be supererogatory for an ordinary citizen observing a burning building. These are examples of the role responsibilities of firefighters. The first example is behavior not permitted to others in everyday life, and the second is neither required nor expected of people in ordinary circumstances. A person with poor swimming skills is not required to do what a lifeguard must do to save a drowning person in rough or deep water. Parents may discipline their own children in ways that would not be permitted if a neighbor's child were engaging in the same behavior. Parents clearly also have obligations in caring for their children that they do not have with other people's children. Rhodes's narrow focus on the medical profession fails to look at the various occupational, familial, and other role responsibilities people have in the course of their daily lives.

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Application of Common Morality to the COVID-19 Pandemic

The COVID-19 pandemic provides vivid illustrations of the way in which common morality is globally applicable (contrary to Baker's contention), as well as providing a standard for both ordinary people and the medical profession (against Rhodes's position). In this analysis, I use a simplified version of the original "four principles" at the heart of common morality: respect for autonomy, nonmaleficence, beneficence, and justice (understood here as equitable distribution of resources). The pandemic serves as a good basis for the analysis since it is global in nature, affecting all people whatever their age, race, ethnicity, or occupation, including medical professionals.

The first point to note is that the principles are not arranged in a lexical or hierarchical order. This means that no one of the principles automatically takes precedence over others when they apply to the same situation. The reason so much controversy has raged over the wearing of masks, the need for social distancing, the willingness to be vaccinated, the use of vaccine "passports" or certificates, and the global distribution of preventive vaccines is that defenders and critics in these situations rank the principles differently when they come into conflict. The following is a brief account of these situations.

It is not only in the United States, with many individuals' fierce adherence to their right to autonomy, that rules requiring the wearing of masks and adherence to social distancing have been criticized and flouted. Newspaper accounts from various countries in the world attest to this phenomenon. In India, Prime Minister Modi has held huge political rallies, and a massive celebration of a Hindu holiday took place on the banks of the Ganges with unmasked participants sitting or standing cheek to jaw.[26] In Israel, an estimated 100,000 ultra-Orthodox Jews gathered to celebrate a holiday, and a stampede in a narrow passageway resulted in 45 deaths.[27] Opponents of masks have visited crowded beaches in the United States, Britain, France, Spain, and other countries, despite restrictions by authorities in some of those places. The point, of course, is that only by adherence to these and other restrictions can transmission of the virus be limited, thereby lowering the impact of the pandemic at least until a large percentage of the population has had access to and is willing to accept effective vaccines. These situations exemplify the clash between the right to autonomy (no masks, I will stand where I want to) and beneficence (maximize benefits and minimize harms). It is not only ordinary citizens who have flouted restrictions imposed on their behavior or refused to be vaccinated. Governmental figures, religious leaders and their followers, owners of commercial establishments, and yes—even doctors and other health workers—have been noncompliant.

This last point applies only to the refusal to be vaccinated. As a matter of customary practice, doctors and other health workers have always worn masks and they are unable to maintain social distancing in their work. Masking and frequent handwashing have long been part of the practice of hygienic medicine and are widely adhered to. But it is surprising to see objections by some medical professionals to receiving one of the five or six vaccines currently approved for emergency use throughout the world. These individuals place the principle of their right to autonomy (refusal to be vaccinated) above that of nonmaleficence (do not harm) or beneficence (maximize benefits and minimize harm). The same ranking of principles occurs in ordinary people's refusal to be vaccinated, so Rhodes's argument might conclude that doctors do, in fact, have specific obligations that ordinary citizens lack. However, some of those ordinary citizens also have occupations or everyday circumstances that place others at risk if they refuse to take proper precautions to avoid infecting those with whom the nature of their work requires them come into close contact. Delivery people, salespersons in stores, workers in public transportation, teachers, plumbers, and electricians who enter people's homes to fix things, and numerous others who refuse to be vaccinated place people at risk. One might argue that doctors and health workers have a greater obligation than ordinary people simply because they work in the health area, which by its very nature requires proper precautions. That is no doubt true, but it is a matter of degree, not a difference in kind between health professionals and other workers. The fundamental point here is the clash between two leading principles of common morality, and how these principles lie at the heart of disputes and debates the world over. It is not at all clear how Baker's human rights approach would analyze and seek to resolve this situation.

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Vaccine passports or certificates are already in use in the country of Israel, in New York State in the United States and elsewhere, with more countries contemplating requiring them for entry. China has issued digital vaccine passports to their citizens to enable them to travel internationally.[28] India, a country with a raging epidemic and a very small percentage of vaccinated people, has issued a vaccine passport with the pronouncement, "Together, India will defeat Covid-19." Next to that statement is a photo of the country's prime minister, Narendra Modi.[29] Multiple international organizations have begun to set standards and coordinate work on vaccine passports for international travel, including the World Health Organization (WHO) and the World Economic Forum. But it is not only for international travel that certificates of vaccination are in use or contemplated. Commercial establishments like sports arenas, restaurants, and concert venues are among the places that have already implemented or are still considering requiring such passes—typically digital—for entry. In Denmark, hair salons, tattoo businesses, massage parlors and driving schools opened exclusively to customers with Coronapas, the country's official document established for this purpose.[30]

It is not surprising that opposition to such requirements has arisen among members of the "anti-vaxx" movement. One argument, even among people willing to be vaccinated, is that such requirements are an invasion of privacy. Having to show proof of vaccination allows outsiders to have medical information about the individual, they argue, whereas medical records should remain confidential. This is one application of the principle, respect for autonomy. Another version is the claim that proof of vaccination implicitly requires that individuals holding a vaccine pass be vaccinated. For them, requiring an anti-COVID vaccination is an unwarranted limitation on their liberty. (Of course, this is the case only if the certificate is not a fake. An example of "common immorality" is the emerging practice of forged or falsified vaccination cards.[31]) On the opposing side of this debate, proponents of proof of vaccination invoke the public health rationale for widespread vaccination: the health benefits to the population outweigh the risks. This defense uses the principle of beneficence, and here again two principles of common morality come into conflict. Yet another argument in opposition to vaccine certificates is the inequities that exist in many parts of the world, including among poorer classes and minorities even in wealthy countries. People who lack access to vaccinations—at least thus far into the pandemic—are therefore shut out of places their wealthier or more fortunate fellow residents may enter. This goes to the heart of the principle of justice, in the form that requires equitable distribution of goods and services.

At this point in the global pandemic, equitable access to anti-COVID vaccines is far from being universal. The reigning principle has been "vaccine nationalism": with few exceptions, wealthy countries have refused to share their vaccine supply with countries lacking access. Only when the U.S. government realized that the country had a surplus of vaccines did it develop a plan to share the supply with other countries. The failure of nations to honor the cooperative international arrangement with the WHO known as COVAX is a breach of their previously stated endorsement of that plan. One human rights instrument is relevant in this context. The UNESCO Universal Declaration on Bioethics and Human Rights, which Baker cited, addresses the issue of international cooperation in Article 15, Sharing of Benefits. It says: "1. Benefits resulting from any scientific research and its applications should be shared with society as a whole and within the international community, in particular with developing countries. In giving effect to this principle, benefits may take any of the following forms…." The key provision in the list that follows is: "(c) provision of new diagnostic and therapeutic modalities or products stemming from research."[32] This is obviously meant to include preventive modalities, such as the anti-COVID vaccines currently approved in many countries for emergency use.

Universality of Common Morality

To claim that common morality is universal is not to imply that individuals or governments always adhere to its precepts. I referred earlier to "common immorality," examples of which are too numerous to illustrate. As I have argued, the principles embodied in common morality apply to human beings in their ordinary lives—in their occupational roles, as parents, caregivers, and anywhere there is interaction with

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other human beings. Members of the medical profession constitute one among many of the roles in which people have special privileges and responsibilities. Human rights embody many ethical obligations, most of which fall on governments to respect, protect, and fulfill. The moral agents in the human rights declarations and treaties are primarily nation-states, not individuals. It is true, however, that "nonstate actors serve as promoters/protectors as well as violators of human rights."[33] Understood broadly, moral agents can be individuals, nation-states, corporations, NGOs, private clubs, universities…the list goes on. Common morality provides a method of ethical analysis that applies to all moral agents. As shown in the COVID-19 illustrations above, common morality plays a role not only in determining whether actions comply with or violate ethical principles, but also in analyzing situations when any of its main principles conflict with one another. One does not have to be a philosopher to employ the principles of common morality. The "common man or woman" uses them all the time, in everyday life. That is an important feature of its universality.

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