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ARTICLE

Common Morality Principles in Biomedical Ethics: Responses to Critics

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Abstract

After briefly sketching common-morality principlism, as presented in *Principles of Biomedical Ethics*, this paper responds to two recent sets of challenges to this framework. The first challenge claims that medical ethics is autonomous and unique and thus not a form of, or justified or guided by, a common morality or by any external morality or moral theory. The second challenge denies that there is a common morality and insists that futile efforts to develop common-morality approaches to bioethics limit diversity and prevent needed moral change. This paper argues that these two critiques fundamentally fail because they significantly misunderstand their target and because their proposed alternatives have major deficiencies and encounter insurmountable problems.

Keywords: common morality; principles; principlism; medical ethics; human rights; moral change

This paper explicates and defends the common morality account of biomedical ethics that we have developed over the last 45 years in the context of our work on what is often called principlism or the four-principles approach, published in several editions of *Principles of Biomedical Ethics* (*PBE*) and in other works.[1] We do so by responding to two different recent sets of challenges to appeals to common morality, showing how those challenges fail. The first challenge holds that medical ethics is autonomous, distinctive, unique and thus not a form of, or justified or guided by, a common morality or indeed by any external morality or moral theory. The second holds that there is no common morality and that efforts to promote common morality approaches to bioethics are doomed to fail and limit diversity and preclude significant moral change. We start with a brief sketch of *PBE*'s common morality framework of principles before responding to these criticisms.

Common Morality Principlism: A Sketch

PBE defines the common morality as the "set of universal norms shared by all persons committed to morality."[2] From these norms, we draw or formulate several principles of obligation, rights, and virtues and join them with an account of moral ideals. We here focus on the broad, abstract, and content-thin principles of obligation that serve as "starting points" and "building blocks" for biomedical ethics: respect for autonomy, nonmaleficence, beneficence, and justice. *PBE* also features several selected rules that, among others, are derived from one or more of these principles: veracity, privacy, confidentiality, and faithfulness (e.g., promise keeping). All these principles and rules have two features or dimensions that require processes to connect them to real-life situations. On the one hand, they are indeterminate and thus require further specification to generate more definite content (e.g., in rules of informed consent). On the other hand, they are all *prima facie* binding, that is, each principle or rule is binding, other things

being equal. Any principle or rule can override others or be overridden by others in particular circumstances.

Because they are not ranked a priori in terms of their weight or importance, balancing or specification is required when principles and rules conflict. Through these processes of specification and balancing we seek what is often called reflective equilibrium or moral coherence. These processes of specification and balancing also generate norms of particular moralities, including particular sociocultural traditions and professional moralities (for instance, medical ethics, research ethics, nursing ethics, and the like). Diversity is expected and respected in particular moralities, as long as their norms do not violate norms of the common morality.

This sketch of our framework is designed to enable unfamiliar readers to understand the targets of criticisms leveled by Rosamond Rhodes and Robert Baker against *PBE* and our responses to those criticisms. Our explications and rejoinders will fill out this sketch in several ways.

Severance of Medical Ethics from Common Morality: A Response to Rhodes

Common Morality and Particular Moralities

Rosamond Rhodes' recent book, *The Trusted Doctor: Medical Ethics and Professionalism*,[3] challenges common morality accounts of medical ethics and proposes an alternative contractarian constructivist account of widely accepted duties in medical ethics and medical professionalism. Rhodes does not enter into debates about whether there is a common morality, and, if so, what its content might be. Instead she argues that common morality approaches to biomedical ethics or bioethics, as developed by us in *Principles of Biomedical Ethics* and by Bernard Gert, Charles Culver, and Danner Clouser in *Bioethics: A Return to Fundamentals*[4] and *Bioethics: A Systematic Approach*,[5] mistakenly attempt to base medical ethics on common morality, that is, on ordinary ethics and morality. Such approaches, she contends, fail to recognize that medical ethics is "radically different," "distinctive," "special," "unique," and cannot be derived from common morality.

Rhodes concedes that "the common morality approach may still be appropriate for guiding public policy related to healthcare,"[6] but she fails to see that the line between what belongs to doctors to decide and what belongs to society to decide through public policy is contested and requires ongoing attention, negotiation, and resolution in light of common morality, and, moreover, that whoever the decision-maker is, common morality provides relevant norms for guiding and assessing actions. As a result, we argue, her theory damages professional medical ethics by isolating, insulating, and shielding it from common morality and from important external criticism by individuals or groups outside of medicine—criticism and suggestions that are often invited by medical associations and government bodies that reach out for advice from experts in clinical ethics or research ethics, for example.

PBE's distinctions and relations between the common morality and particular moralities, including medical ethics, are more nuanced than Rhodes recognizes. The norms of the common morality are abstract, universal, and content-thin—for example, "tell the truth." By contrast, norms of particular moralities such as those in clinical ethics and research ethics are concrete, nonuniversal, and content-rich. For example, they could specify "tell patients about their prognosis of death from newly diagnosed cancers but do so in a staged fashion in order not to destroy their hope." More broadly, particular moralities include various sociocultural moralities, religious traditions, and the like, as well as professional moralities. These present a range of duties, virtues, and ideals for their constituents.

Professional morality in medicine regularly specifies general moral norms for the institutions and practices of medicine, in order to produce rules that match particular roles and relationships in medicine.[7] This process of specification takes account of the particular aims, roles, relationships, contexts, and circumstances of medicine—it brings general moral norms to bear on these particular features of medicine. For instance, general principles of respect for autonomy, beneficence, and nonmaleficence justify rules of confidentiality and informed consent in medicine and human subjects research.[8]

Rhodes's critique of *PBE*'s conception of the relation between the common morality and particular, professional medical morality relies heavily on overstatement and exaggeration. She attributes to *PBE* "the common view of medical ethics as *merely* an extrapolation of the principles of common morality," as "*nothing more than* narrowly specified conclusions from common morality," and as "*just* common morality applied to the medical field."[9] And yet she also admits that *PBE* recognizes that particular moralities, including professional moralities, may "vary from common morality."[10] This is what we hold, with a crucial proviso: Norms of particular moralities "*are not morally justified if they violate norms in the common morality*."[11] In short, while emphasizing that particular moralities specify norms of the common morality, *PBE* recognizes the legitimacy of particular moralities in medicine and elsewhere even when they are not solely *derived from* the norms of the common morality as long as they are consistent with those norms. Rhodes rejects this proviso. She claims not only that medical ethics is not derived from common morality but that it is "incompatible" with common morality.[12] This is a shocking conclusion for which we see no justification in her work or elsewhere.

Uncommon Morality and Particular Morality: Theory, Method, and Duties

In opposing "the reigning common morality view of medical ethics," as found in *PBE* and in the work of Gert and colleagues, Rhodes presents what she describes as an "uncommon morality account," which begins by "stripping doctors from their mooring in common morality."[13] This implausible and potentially dangerous idea has several implications.

First, it indicates that "duties of physicians are *distinctive* and *different from* the duties of common morality."[14] "Distinctive" is fine, but what conceivably could justify the claim that they are different from the duties of common morality? In our account, physician duties are built on the norms of common morality and differ from duties of common morality only by being distinctive for one or more particular groups of physicians (e.g., those who are governed by the standards of clinical ethics and those who governed by the standards of research ethics). Such standards constitute *particular moralities.*[15] Physicians have many duties and role responsibilities that nonphysicians do not have, but to call them "uncommon" is misleading. Most of these moral duties and responsibilities are rooted in common morality principles, virtues, and rights and in this respect are not uncommon.

Second, Rhodes indicates that the "ethics of medicine [is] internal to the profession."[16] The duties of medical ethics are not derived from norms and values external to the profession; hence, medical ethics must be viewed as independent and autonomous.[17] This conclusion is false for medical ethics and, indeed, for all practical ethics of professions such as public health, nursing, and so forth. Moreover, it is a dangerous nightmare for public policy. We cannot imagine how such a view could be justified. Duties of medical care and research are clearly governed by external values of the common morality and morally cannot deviate from or reject those standards. In the history of what we now regard as duties of disclosure and informed consent, for example, physicians often neglected to obtain valid consents in order to protect or benefit patients; but it later became obvious in biomedical ethics that allowing duties of beneficence to override duties of respect for autonomy as a matter of general practice is a faulty understanding of medical ethics. Gradually, practices of informed consent replaced practices of paternalism in clinical ethics and forms of exploitation in biomedical research. This process involved bringing common morality norms such as respect for autonomy, truth-telling, and honesty to bear on physician practices.

Third, Rhodes insists that medical ethics is "constructed by medical professionals for medical professionals."[18] Because doctors "are the only ones who can adequately understand what is involved, appreciate the potential risks and benefits of their services, and distinguish competent practice from unacceptable performance," they alone can define the duties of the profession.[19] This ancient theory at one time did prevail as an uncommon morality in medicine, but in the last five decades it has largely and rightly been discredited and dismissed. The judgment that it was wrong came from many professions, including physicians who criticized practices they came to see as unacceptable, often in light of external standards. An outstanding example is found in Jay Katz's book *The Silent World of Doctor and Patient.*[20]

Rhodes locates her account within the "contractarian constructivist tradition."[21] Having pulled medical ethics away from common morality, she tries to explicate it by examining its construction and rationale. Society grants doctors "special powers, privileges, and immunities that are permitted to no one else," and in turn doctors and other medical professionals construct standards to which they adhere to gain trust and to be worthy of that trust.[22] Given society's license to medicine, "[t]he fundamental and core guiding first duty of medical ethics is to seek trust and be deserving of that trust. It is the source from which all of the other more specific duties are derived."[23] All of the other duties are "inferences" from this "fundamental duty"[24]; they are all "necessary means to achieve or maintain trust."[25] Rhodes is here creating a trust-based medical ethics. We can all agree that trust is exceedingly important in medical practice and research, but to try to derive all other duties from this duty is highly questionable. From our perspective, duties of trust are themselves largely derived from common morality and the specification of its principles in medicine and research, rather than being derived from an *uncommon* morality of medicine.[26]

Rhodes' method for identifying duties and resolving conflicts among them is close to what is often called rule consequentialism: certain ends and consequences are captured in a principle or rule that serves as the *source* of other duties and serves as a *touchstone* to resolve conflicts among other duties. The "fundamental duty" to seek trust and to be trustworthy serves both functions in medical ethics. Beyond this fundamental duty, there is no hierarchy or priority ranking among the other duties of medical ethics —they all have "equal standing."[27]

Rhodes' expansive list of duties includes: (1) Seek trust and be deserving of it; (2) Use medical knowledge, skills, powers, privileges, and immunities to promote the interests of patients and society; (3) Develop and maintain professional competence; (4) Provide care based on need; (5) Be mindful in responding to medical needs; (6) Base clinical decisions on scientific evidence; (7) Maintain nonjudgmental regard toward patients; (8) Maintain nonsexual regard toward patients; (9) Maintain the confidentiality of patient information; (10) Respect the autonomy of patients; (11) Assess patients' decisional capacity; (12) Be truthful in reports; (13) Be responsive to requests from peers; (14) Communicate effectively; (15) Police the profession; (16) Ensure justice in the allocation of medical resources.[28]

This is a mishmash of duties, hardly all on the same level and some plausibly derived from one or more of the others. At best it is "unwieldy"—to use one of Rhodes' favorite epithets for common morality frameworks that stand against her account. She proclaims continuity in these duties in particular medical moralities across cultures and across time, and views her novel contribution as providing an "uncommon morality" theory to account for them. However, it strains credulity to hold that respect for patient autonomy in clinical care and justice in the allocation of medical resources have long been central features of medical ethics across cultures and time. They appear to be, for the most part, relatively recent developments in particular moralities of medicine and research, arguably the result of interpretations or reinterpretations of common morality principles and their implications for medicine in different sociocultural contexts. Indeed, they arguably result from contributions in biomedical ethics over the last half of the twentieth century in which new codes, government regulations, and the like emerged through specifications of general moral principles that had not been so clearly recognized in medicine, law, and public policy. The "uncommon" moral codes and practices of physicians such as so-called Hippocratic ethics were heavily revised or dispatched in the process.

Neglected Duties: Beneficence/Nonmaleficence

It is noteworthy that beneficence and nonmaleficence are missing from Rhodes' sprawling catalog of specific ethical duties in medicine, despite, for instance, the frequently referenced duty in the Hippocratic tradition and beyond of not doing harm. Rhodes' reasons for omitting them reflect her relentless quest to strip medical ethics from all connections with common morality, expose the futility of this quest, and suggest the damage it inflicts on medical ethics—all points we elaborate in what follows.

Rhodes insists that the principles of beneficence and nonmaleficence[29] can be omitted because they "merely express the negative content of ordinary morality. … Hence, they are not specific features of the ethics of medicine."[30] This thesis is truly odd. As physician Edmund Pellegrino together with coauthor David Thomasma argue in their book, *For the Patient's Good: The Restoration of Beneficence in Health Care*, beneficence is arguably the central principle in medical ethics for determining the responsibilities of physicians.[31] We certainly concur that it is *a* central principle, and we think nonmaleficence is as well. It is unimaginable that they could be omitted as Rhodes proposes. The fact that these principles capture morally significant features of action outside medicine does not render them irrelevant to medicine. In her zeal to flag the "radical difference" of medical ethics, Rhodes deliberately omits what is *essential* just because it also appears elsewhere and thus is not *unique* to medicine.

Rhodes contends that examining beneficence and nonmaleficence is "not illuminating because it adds nothing to our understanding of medical ethics"; they are "redundant expressions of medicine's fiduciary responsibility," and don't involve "a dilemma that arises from unusual circumstances."[32] However, Rhodes' claims do not justify downplaying the ethical significance of beneficence and nonmaleficence within medicine (or between medicine and society). On Rhodes' own terms, these appear to be warranted and even required by her conception of the first and fundamental duty of securing trust. It appears that her strategy is designed in part to shield medical ethics and doctors' responsibilities from the potentially expansive reach of the duties of beneficence and nonmaleficence to nonpatients and to society.

The Duty of Confidentiality: Source and Resolution of Conflicts

We will use Rhodes' examination of the duty of confidentiality to highlight some features and deficiencies of her "uncommon morality" argument, particularly as it doggedly seeks to sever professional medical morality from common morality. She sweepingly and dismissively states that "common morality plays no part in justifying [the standards of] required physician behavior."[33] This judgment presumably applies to the justification of various duties and exceptions to those duties.

In Rhodes' account, duties of medical confidentiality, like the other listed duties, have their source and justification in the fundamental first duty to seek and maintain trust and be worthy of trust. In her argument, confidentiality is essential for patients to be willing to share "secrets of their history and bodies in the course of their treatment."[34] Proponents of common morality approaches can largely agree with this argument and conclusion. For instance, in justifying a *prima facie* rule of confidentiality *PBE* appeals to the consequentialist dimensions of the principles of beneficence and nonmaleficence, with particular attention to the importance of patient trust, alongside the nonconsequentialist principles of respect for autonomy and privacy.[35]

There are serious problems in Rhodes' account of how the duty of securing trust also serves as the "touchstone" for resolving conflicts among duties in particular circumstances. As doctors work through Rhodes' template for making decisions, they are expected to consider "which alternative action is more likely to preserve society's trust and which is more likely to erode or undermine the trust"; this determination should be based on "professional consensus," rather than on doctors' personal preferences or on public opinion polls.[36] Rhodes does not stress clinical ethics consultation even though such consults are commonly used in practice.

While Rhodes claims to set the bar "very high" for justifying exceptions to the duty of confidentiality, she finds "some circumstances that justify violating confidentiality (e.g., situations involving impaired physicians or other medical professionals)."[37] Her examples are telling, and the exceptions she mentions mainly involve disclosures that could reduce the likelihood that impaired medical professionals will continue to put patients at risk.

More telling is her procedure for justifying exceptions. Exceptions can be justified in her account when the breach of confidentiality is "consistent with upholding the trustworthiness of the profession," when "experienced and esteemed medical professionals would agree that the particular violation of confidentiality was justified," and when "a consensus of respected and experienced colleagues" supports the exception in an institution's policy.[38] It is not clear why esteemed physicians are the ones who can

best determine whether the public and patient trust that is sought, as required by the first principle, would be maintained or damaged by the exception. This closed circle of justification, limited entirely to medical professionals, represents a flaw in Rhodes' theory that results, at least in part, from her efforts to exclude common morality considerations. Even though patients and the public are not in Rhodes' prescribed and severely limited inner circle, they are the ones whose trust is crucial and their actual or hypothetical or imagined responses likely and often legitimately reflect considerations from common morality, including beneficence and nonmaleficence that attend to and balance the benefits and harms of disclosing confidential information.

PBE's approach to exceptions to duties of confidentiality is superior in several respects. First, while *PBE*'s circle of ethical justification includes various medical professionals, it is intentionally not narrowly limited to them. *PBE*'s approach is not burdened and limited by a condition such as Rhodes' for evaluating the resolution of the conflict "by asking if it is what a consensus of exemplary doctors would agree is the resolution that would uphold the trustworthiness of the profession."[39] Indeed, moral justification is explicitly not made contingent on or restricted to the judgments of exemplary medical professionals. In biomedical ethics moral justification often works best when it is intentionally structured along multidisciplinary rather than disciplinary lines and includes public stakeholders. National Commissions and Committees have repeatedly shown how advances in biomedical ethics occur through multidisciplinary bodies with public participation.

Second, by omitting ethical duties of beneficence and nonmaleficence that include but also extend beyond medical relationships, Rhodes blocks the possibility of dealing adequately with moral pressures for exceptions to rules of confidentiality—that is, duties to prevent or remove harm or to promote benefits, which may conflict with confidentiality in some cases. An example is debate about a possible moral (and perhaps legal) duty for mental health professionals to warn intended victims, who are not the professional's patients, of a client's threatened violence.[40]

Third, despite Rhodes' criticisms, *PBE*'s use of specification and constrained balancing, coupled with reflective equilibrium, does provide a fruitful structure for addressing conflicts. For instance, the structure of constrained balancing includes several of the conditions that Rhodes invokes in her own analysis of cases and indeed provides better guidance than hers for resolving a clinical ethical dilemma.[41]

Deficiencies and Dangers in Rhodes' Uncommon Morality Account

Rhodes' "uncommon morality account" calls for a severance of medical ethics from common morality on the grounds that they are "incompatible."[42] We see no reason to think this claim is correct, and it seems problematic for several reasons. First, it is unrealistic. Historically, among Rhodes' 16 duties of professional medical morality, several either originated in or came to the fore as a result of support based on common morality principles. For instance, respect for autonomy and distributive justice had largely been ignored or underplayed in traditional medical ethics but have been profoundly influential in recent biomedical ethics, as is evident in the publications of professional associations in medicine. The total severance that Rhodes seeks is unlikely to be achieved because work in the ethics of medical practice and research is now thoroughly multidisciplinary and that work is recognized as highly important by many medical institutions and associations.

An interesting example comes from the U.S. National Academy of Medicine (NAM), which is part of the U.S. National Academies of Sciences, Engineering and Medicine. For years the NAM has increasingly sought help in formulating its recommendations for policies from figures in ethics, law, public health, and several other fields that are not exclusively medical. Frequently the chairs of its committees dealing with moral problems are not physicians. The NAM also annually presents the Adam Yarmolinsky Medal for exceptional service to a member whose discipline falls outside the traditional health sciences (although the person's degree or degrees may be in one or more of these sciences). This award, which was initiated in 2000, has often gone to members whose central writings are on biomedical ethics, including Lawrence Gostin, Alta Charo, and Ruth Faden. Many other members and nonmembers who

are in or contribute significantly to biomedical ethics also serve on and chair study committees for the NAM.

Second, a *distinctive* professional morality for physicians (and other health professionals) can be recognized without severing it from common morality. Well-crafted professional medical ethics can emphasize several distinct obligations, virtues, and ideals, without being different through and through. Overlap, even substantial overlap, with other particular moralities and with the common morality does not eradicate distinctiveness, even if it limits the extent of distinctiveness. Moreover, Rhodes never adequately explains why we should highly prize "radical difference," "distinctiveness," or "uniqueness" in medical ethics. This idea too seems very odd.

Third, trying to achieve the unrealistic and unnecessary goal of total severance predictably leads to an unproductive and dangerous isolation and insulation of medical ethics. Many—perhaps most—of the central norms of medical ethics serve to specify and balance common morality norms for the professions of medicine, nursing, public health, and so forth. Even the norms that do not can be warranted, as we have argued, only if they do not violate the common morality.

In contrast to Rhodes, we hold that it is vitally important to institute and maintain ongoing dialectical interactions between medical ethics and common, everyday morality, including the common morality norms articulated in *PBE.* One reason is to incorporate the moral experience of professionals into our understanding of the implications of common morality for the medical profession and medical ethics. Another reason is to prevent insularity in medical ethics. Insularity can allow and fuel widespread paternalism in violation of respect for autonomy and further neglect of social justice. We think that the ethics proposed by Rhodes would likely result in the return of the kind of medical paternalism that was largely dispatched in the twentieth century.

Challenges to Common Morality's Content, Impact on Diversity, and Barriers to Change: A Response to Baker

We now turn to philosopher Robert Baker's critique of common morality. Whereas Rhodes seeks to sever all ties between common, everyday ethics and professional medical ethics, Baker opposes common morality approaches in bioethics as fictional and as threats to moral diversity and moral change.

An Inflated Account of Common Morality's Content

We first respond to Baker's attack on our claims of a universal common morality. At points, his attack simply misses its target because it aims at positions that we do not present in *PBE.* A slide in Baker's presentation at the Symposium on "Common Morality, Solidarity, and Trust" at the 15th World Congress of Bioethics stated: "Historically, there is not now and never has been a universal common morality re femininity/masculinity, retributive justice (lex talionis vs rehabilitation), gay sex as perverse vs healthy, infanticide/abortion, euthanasia."[43] To this thesis we can only respond—of course not, and we agree. We have never claimed to have produced such a content-full common morality, as we have pointed out in *PBE* and in a number of our prior articles in defense of *PBE.* Elsewhere when Baker denies the existence of common morality, he also presupposes, even if he states it less clearly, a thick conception of common morality; his first concern about "a single, authoritative set of moral concepts and norms that is universally applicable … is simply that a common morality does not exist, never has, and, moreover, never should. Full stop. Period."[44] He thinks of our conception of common morality as shared morality all the way down to particular conclusions about the use of dead bodies in medical education, research, or transplantation or about the legitimacy of abortions of fetuses; but this is emphatically not what *PBE* holds about common morality.

As previously noted, we define the common morality as the "set of universal norms shared by all persons committed to morality."[45] These norms are an unconnected heap of obligations, as well as ideals, virtues, and rights. They are the "source of considered judgments" in the sense that we draw or derive or

formulate the four principles—respect for autonomy, nonmaleficence, beneficence, and justice—from those common morality norms. As "considered judgments," these principles serve as "starting points" and "building blocks" for biomedical ethics, which we then extend by seeking coherence through the process of reflective equilibrium involving both specification and balancing.[46]

The principles we identify and develop for biomedical ethics are broad, abstract, and content-thin. Hence, a major question concerns how to connect these principles to concrete situations, whether in clinical decision making or in public policy. The aforementioned processes of specification and constrained balancing are crucial for making these connections. Specification, as the term suggests, produces greater specificity in the interpretation and application of principles, while also often preventing or removing conflicts with other principles by clarifying when, where, how, and to whom they apply. This process focuses on the range or scope of principles. Another dimension is their weight or strength. We address this through the process of constrained balancing that reaches judgments in particular situations and that determines which principle or rule outweighs or overrides another or others in those situations.[47] The principles and rules derived or drawn from the norms of the common morality and their further specifications are not, strictly speaking, part of common morality even though they derive from it in critically important ways. In contrast to Baker's interpretation, *PBE* does not hold that judgments about abortion, euthanasia, and the like are part of common morality or have the same authority as common morality even though they may represent efforts to specify and balance the norms derived from common morality. Nonetheless, we believe that most well informed deliberations and judgments about these problems will—indeed must—take account of considerations that derive from common morality.

Absolute Principles: Are There Any?

Baker's critique contains another misunderstanding of *PBE*'s conception of common morality—that it consists of a "set of universally *absolute* common moral truths."[48] We understand "absolute" here to mean binding unconditionally, without exception. We do not hold that the moral norms we derive from the common morality for guidance in biomedical ethics are absolute in this sense, as we repeatedly point out in *PBE.* They are only *prima facie* binding, that is, binding other things being equal, and each one of them can thus be overridden by one or more *prima facie* norms in cases of contingent conflicts, for instance, between beneficence and respect for autonomy in the care of patients. In such situations, processes of specification and constrained balancing are employed to mitigate or resolve the conflict.[49]

However, we do not deny that the process of specification occasionally generates absolute norms: "Some specified norms are virtually absolute and need no further specification, though they are rare. Examples include prohibitions of cruelty that involves unnecessary infliction of pain and suffering. 'Do not rape' is a comparable example."[50] These are specifications of several of the four principles *PBE* emphasizes—respect for autonomy, nonmaleficence, beneficence, and justice. Very few principles or rules are absolute or unconditional. Most ethical discourse—in general and specifically in bioethics—involves principles and rules that are *prima facie* binding, and that can be further specified and balanced in seeking to achieve and to increase coherence.

Common Morality and Moral Diversity

Baker charges that common morality theories preclude moral diversity—and so stand as a form of "cultural imperialism" that invites "intolerance."[51] This is a serious misunderstanding. We again emphasize *PBE*'s distinction between the common morality and particular moralities. Particular professional moralities like medical ethics often specify—and should specify—norms of the common morality, but the specific norms of these particular moralities can be legitimate even if not offered as specifications of the common morality as long as they do not *violate* the norms of the common morality and do not produce some kind of moral incoherence.[52]

Consider the following two examples. First, *PBE* argues for universal access to health care on grounds of principles derived from common morality, especially *justice* and *beneficence*.[53] In some European cultures *solidarity*, understood as a robust "nonsexist ideal of 'fraternity,' of all for one and one for all," justifies vital societal support for national health insurance systems.[54] Baker takes this difference between *PBE*'s principle-based justifications and solidarity-based justifications as an argument against *PBE*'s conception of common morality.[55] However, solidarity should be viewed as a particular sociocultural moral ideal that does not contradict norms of obligation drawn from the common morality, and nothing prevents a common morality principlist from appealing to solidarity in particular sociocultural contexts.

Second, in a discussion of *PBE*, some scholars in Hong Kong stressed that Confucian ethics, in contrast to more liberal, individualistic frameworks in Western societies, takes for granted obligations and virtues of filial piety, recognizes obligations of children to care for their parents, and argues that governments should promote the fulfillment of those filial obligations.[56] This kind of moral diversity in identifying moral agents and their responsibilities is certainly within the bounds of principles derived from the common morality and in no way contradicts them. Making the principles more determinate in identifying *who* should be the primary moral agents and *what* they should do in caring for elders in a society requires specification or balancing or both. Reasonable differences can be expected. We should not anticipate uniformity everywhere the four principles are accepted and shared as starting points. But diversity in particular moralities and varied specifications and weights for principles drawn from the common morality do not indicate relativism in the common morality or in universal morality.[57]

Does Common Morality Theory Present a Barrier to Significant Moral Change?

Baker further charges that common morality frameworks are "dangerous fictions" that "reify" a "static" and "inflexible" conception of morality, thereby impeding moral development and hampering a society's capacity to respond to "morally disruptive socioeconomic and technological change."[58] According to Baker, "Fettering a society to a single set of paradigms, concepts, norms, and laws would undermine the natural processes of moral reform and moral revolution that enable societies to adapt their paradigms, concepts, norms, and laws to morally disruptive challenges."[59]

Despite Baker's concerns, *PBE*'s conception of the common morality does not create a barrier to moral reform or to moral revolution, and we present a clear position on the nature and possibilities for justified moral change in chapter 10.[60] In addition to this section, one of our central positions in methodology in biomedical ethics is specification, which itself can be considered a way of introducing moral change in many situations.

In his *The Structure of Moral Revolutions*, Baker distinguishes between "moral reforms, in which underlying paradigms retain their nonnegotiable status, and moral revolutions that alter areas of morality once deemed unalterable."[61] Moral reforms are less problematic because they mitigate the harms produced by the underlying paradigm, rather than changing that paradigm. Moral revolutions, by contrast, alter areas of morality previously considered nonnegotiable. Schematically, it appears that in revolutionary moral change, a prohibited (or required) X now becomes optional, an optional X now becomes prohibited or required, a prohibited X now becomes required, or a required X now becomes prohibited. Particular moralities can and do undergo such changes without posing serious philosophical problems, though they are usually associated with complex and often turbulent sociocultural problems. But what about a common, universal morality?

Once Baker's conception of what is involved in common morality theories is deflated (including, e.g., specific acceptance or rejection of abortion or of physician assisted death) and we consider thinner conceptions of the sort we defend in *PBE*, significant moral changes can occur even under the type of universalist theory that we propose. However, the notion of a common, universal morality is not compatible with a rejection or fundamental alteration of basic norms. Significant changes, even groundbreaking changes (as happened, e.g., in the development of informed consent requirements), can and do occur through specifications of those norms, particularly by altering their scope of

applicability (i.e., the range of individuals or groups covered by the principles or rules) or by building exceptions into the specified principle or rule (e.g., by limiting the circumstances of applicability), as *PBE* discusses under the heading of "moral change."[62]

Changes in the recognized moral status of some individuals or groups also can alter the scope of applicability of moral principles such as nonmaleficence and respect for autonomy. These have produced some of the most significant reformist and revolutionary moral changes over time. Consider, for instance, how proposed changes—often only partially realized—in the treatment of women, minorities, fetuses, and nonhuman animals have been justified and propelled by changes in views of their moral status. (See chapter 3 of *PBE* for an examination of theories of moral status and for elaboration of these points about moral change.) This process is not grounded only in analytical argument or a new philosophical framework, because it often emerges from and builds on empathy, sympathy, and moral imagination.[63]

In short, significant—even revolutionary—changes can occur in a society's moral views and practices regarding such matters as the abortion of fetuses or the treatment of nonhuman animals, based in part on changes in conceptions of their moral status, without fundamentally altering the norms derived from the common morality.

Human Rights and Universal Principles

Baker maintains that human rights discourse is now "the accepted language of international ethics."[64] This sociological or historical claim is somewhat dubious, although we agree that much of bioethics and many cultures have increasingly recognized the importance of human rights language. But Baker's claim seems to be *normative* as well: "A global bioethics that envisions principles as mechanisms for protecting human rights will … inherit an internationally accepted discourse."[65]

It is not clear that Baker's normative views on human rights are consistent with his own accounts of moral diversity and moral change as discussed earlier in this paper, but we need not return to our earlier arguments here. We think that Baker should have no problems with our account of universal principles given his position on human rights. We argue strongly in defense of human rights in bioethics and closely link those rights to universal principles. Both human rights and common morality principles are by their nature universally valid norms. Moreover, we in effect argue that universal human rights entail universal principles and universal principles entail human rights. We use the theoretical construct of the correlativity of obligations and rights to express the tight relationship between universal principles and human rights.[66] Our theory is not identical to Baker's, but the difference between the two accounts need not indicate a difference in moral substance. We do not need to reduce rights to principles of obligation or to reduce principles of obligation to rights, and we see no need for such a reductionist moral theory in bioethics.

Conflict of Interest. The authors declare no conflict of interests.

Notes

1. The first edition of *Principles of Biomedical Ethics* was published in 1979: Beauchamp TL, Childress JF. *Principles of Biomedical Ethics.* New York: Oxford University Press; 1979. In this paper, we refer both to Beauchamp TL, Childress JF. *Principles of Biomedical Ethics.* 7th ed. New York: Oxford University Press; 2013, which recent critics would have had access to, and to Beauchamp TL, Childress JF. *Principles of Biomedical Ethics.* 8th ed. New York: Oxford University Press; 2019, for our most recent statements of our positions.
2. See note 1, Beauchamp, Childress 2013, at 3; 2019, at 3.
3. Rhodes R. *The Trusted Doctor: Medical Ethics and Professionalism*. New York: Oxford University Press; 2020.

4. Gert B, Culver CM, Clouser DK. *Bioethics: A Return to Fundamentals*. New York: Oxford University Press; 1997.
5. Gert B, Culver CM, Clouser DK. *Bioethics: A Systematic Approach*. 2nd ed. New York: Oxford University Press; 2006. (This is the second edition of their book *Bioethics: A Return to Fundamentals* with a new subtitle.) Probably, the most complete statement of Gert's common morality theory appears in Gert B. *Common Morality: Deciding What to D*o. New York: Oxford University Press; 2004.
6. See note 3, Rhodes 2020, at 13.
7. See note 1, Beauchamp, Childress 2013, at 6; 2019, at 6.
8. See note 1, Beauchamp, Childress 2013, at 6–8; 2019, at 7–8.
9. See note 3, Rhodes 2020, at 346, 21, 6 italics added. In support of her claim that *PBE* views particular morality as "merely an extrapolation" from common morality, Rhodes refers to *PBE*, 7th edition, p. 352, where nothing of this sort is discussed or even mentioned. See note 1, Beauchamp, Childress 2013, at 352. See note 3, Rhodes 2020, at 346, fn. 2.
10. See note 3, Rhodes 2020, at 21.
11. See note 1, Beauchamp, Childress 2013, at 5, italics added; 2019, at 5.
12. See note 3, Rhodes 2020, at 29–30.
13. See note 3, Rhodes 2020, at 5.
14. See note 3, Rhodes 2020, at 345, italics added.
15. See note 1, Beauchamp, Childress 2013, at 5–6, 412–15; 2019, at 5–6, 445–49.
16. See note 3, Rhodes 2020, at 345, 31, 40.
17. See note 3, Rhodes 2020, at 38.
18. See note 3, Rhodes 2020, at 345, 31, 40.
19. See note 3, Rhodes 2020, at 31.
20. Katz J. *The Silent World of Doctor and Patient*. New York: Free Press; 1984; reprint ed. Baltimore, MD: Johns Hopkins University Press; 2002. This book relies heavily on the principle of respect for autonomy and its connection to requirements of informed consent.
21. See note 3, Rhodes 2020, at 42, 346.
22. See note 3, Rhodes 2020, at 30–31. Rhodes refers to all medical professionals as "doctors" or "physicians" for economy of expression, but this nomenclature masks several important differences in power and authority in decision making by different professionals in health care, for instance, physicians, fellows, and nurses.
23. See note 3, Rhodes 2020, at 53.
24. At least twice in *The Trusted Doctor*, this fundamental duty is stated as "fundamentalduty," either accidentally as a misprint or deliberately in order to make a point about its centrality and significance. See note 3, Rhodes 2020, at 54.
25. See note 3, Rhodes 2020, at 70. At one point Rhodes suggests that "perhaps we can consider the broad implicit endorsement from the community of medical professionals of the sixteen duties of medical ethics … to be something akin to a Rawlsian 'overlapping consensus.' As I have suggested by employing real and hypothetical examples for deriving the sixteen duties of medical ethics, agreement on those core responsibilities can be achieved through a process of reflective equilibrium." See note 3, Rhodes 2020, at 284, fn. 2. This is not further developed in *The Trusted Doctor*.
26. For a superb analysis of how common morality principles can be brought to bear on real-world problems of medical ethics, see Gordon J-S, Rauprich O, Vollmann J. Applying the four-principle approach. *Bioethics* 2011;**15**:293–300.
27. See note 3, Rhodes 2020, at 54, 68, 93.
28. See note 3, Rhodes 2020, at 286, Table 11.2, The Duties of Medical Ethics.
29. This is not primarily about preserving the language of beneficence and nonmaleficence. Other terms may be used for these clusters of moral duties and activities. The point here focuses on the need to include those moral duties in the list of recognized moral duties or principles.
30. See note 3, Rhodes 2020, at 356.

31. Pellegrino ED, Thomasma DC. *For the Patient's Good: The Restoration of Beneficence in Health Care*. New York: Oxford University Press; 1988.
32. See note 3, Rhodes 2020, at 356.
33. See note 3, Rhodes 2020, at 19.
34. See note 3, Rhodes 2020, at 128.
35. Even though the seventh edition of *PBE*, which Rhodes most often references, is quite clear that both consequentialist arguments (based on beneficence/nonmaleficence and connected with trust needed for diagnosis and treatment) are important along with respect for autonomy and privacy, Rhodes claims that in *PBE* we justify confidentiality "in terms of respect for autonomy." See note 3, Rhodes 2020, at 128, fn. 15. We do both. See note 1, Beauchamp, Childress 2013, at 316–32; 2019, at 342–53.
36. See note 3, Rhodes 2020, at 54.
37. See note 3, Rhodes 2020, at 137, 134.
38. See note 3, Rhodes 2020, at 131.
39. See note 3, Rhodes 2020, at 284.
40. See note 3, Rhodes 2020, at 129–130, fn. 17. Contrast *PBE*: See note 1, Beauchamp, Childress 2013, at 10–11, 208, 319; 2019, at 10–11, 223, 346, 377n70, on the important *Tarasoff* case, which continues to be heatedly controversial and has not gained a settled position in the community of physicians after many years of discussion. This case also concerns the limits of trust.
41. See note 3, Rhodes 2020, at 284, Table 11. See note 1, Beauchamp, Childress 2013, at 17–24, esp. 23; 2019, at 17–24, esp. 23.
42. See note 3, Rhodes 2020, at 29–30.
43. This is from Baker's Slide 12 in his presentation at the Symposium on "Common Morality, Solidarity, and Trust" at the 15th World Congress of Bioethics in June 2020.
44. Baker R. *The Structure of Moral Revolutions: Studies of Changes in the Morality of Abortion, Death, and the Bioethics Revolution*. Cambridge, MA: The MIT Press; 2019, at 211. We respond to a number of our critics who hold this position in chap. 10 of *PBE*; see note 1, Beauchamp, Childress 2019, at 449–56.
45. See note 1, Beauchamp, Childress 2013, at 3; 2019, at 3.
46. See note 1, Beauchamp, Childress 2013, at 2–5, 404–24; 2019, at 3–5, 439–58.
47. See note 1, Beauchamp, Childress 2013, at 17–24; 2019, at 17–24.
48. See note 44, Baker 2019, at 211, italics added.
49. See note 1, Beauchamp, Childress 2013, at 15–25; 2019, at 15–25.
50. See note 1, Beauchamp, Childress 2019, at 19; compare 2013, at 19, using different examples.
51. See note 44, Baker 2019, at x, 213.
52. See note 1, Beauchamp, Childress 2013, at 5; 2019, at 5.
53. See note 1, Beauchamp, Childress 2013 and 2019, chap. 5 and 6.
54. See note 44, Baker 2019, at 212.
55. See note 54.
56. See Childress J, Fan R, Wang M. A dialogue on the four principles of bioethics. *Chinese Medical Ethics* 2020;33(11):1295–9 [in Chinese], and Fan R, Xu H, Cai Y, Zhang Y, Bian L, Wang Q, et al. Ethical principles: Different perspectives. *Chinese Medical Ethics* 2019;32(5):591–601 [in Chinese]. These Chinese scholars contrast Confucian conceptions of filial piety with what they view as the Western liberal, individualist conception depicted in Daniels N. *Am I My Parents' Keeper? An Essay on Justice Between the Young and the Old.* New York: Oxford University Press; 1988.
57. Beauchamp TL. The compatibility of universal morality, particular moralities, and multiculturalism. In: Teays W, Gordon J-S, Renteln AD, eds. *Global Bioethics and Human Rights: Contemporary Issues.* Lanham, MD: Rowman & Littlefield; 2014:28–40.
58. See note 44, Baker 2019, at 211–3.
59. See note 44, Baker 2019, at 213.
60. See note 1, Beauchamp, Childress 2019, at 444–9.
61. See note 44, Baker 2019, at x, 18, 39–49, passim.

62. See note 1, Beauchamp, Childress 2013, at 94, 412–5; 2019, at 445–9.
63. See note 1, Beauchamp, Childress 2013, at 92–4; 2019, at 90–2.
64. Baker R. Bioethics and human rights: A historical perspective. In: Teays W, Gordon J-S, Renteln AD, eds. *Global Bioethics and Human Rights: Contemporary Issues.* Lanham, MD: Rowman & Littlefield; 2014:92–100, at 98.
65. See note 64, Baker 2014, at 98.
66. See note 1, Beauchamp, Childress 2013, at 14, 85, 108, 371–3; 2019, at 405–8, 414, 422n51.

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