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ARTICLE

What is the Foundation of Medical Ethics—Common Morality, Professional Norms, or Moral Philosophy?

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Abstract
This paper considers the relation between medical ethics (ME) and common morality (CM), professional norms, and moral philosophy. It proceeds by analyzing two recent book-length critical analyses of this relationship by Bob Baker in "The Structure of Moral Revolutions—Studies of Changes in the Morality of Abortion, Death, and the Bioethics Revolution" and Rosamond Rhodes in "The Trusted Doctor—Medical Ethics and Professionalism." It argues that despite the strengths of these critical arguments, there is nevertheless a relationship between ME, understood as the professional ethics of the healthcare professions, and both CM and moral philosophy. It also argues that ME cannot and should not be understood purely as the internally developed professional norms of the medical or healthcare professions.

Keywords: common morality; medical ethics; moral philosophy professional ethics

Introduction

What is the relationship between medical ethics (ME) and common morality (CM)? Many, taking their cue from the work of Beauchamp and Childress[1] or the work of Bernard Gert,[2] argue that ME can be derived from CM as a more precise and consistent specification of principles and virtues derived from CM in the context of the role of healthcare professionals (HCPs) and the particular ethical issues that arise in healthcare practice and the healthcare system. This view has been criticized by many, including the author of this paper,[3] but recently, two relatively new and fundamental lines of criticism have been given book-length explications by Bob Baker in "The Structure of Moral Revolutions—Studies of Changes in the Morality of Abortion, Death, and the Bioethics Revolution"[4] and Rosamond Rhodes in "The Trusted Doctor—Medical Ethics and Professionalism."[5] In this paper, I will present, analyze, and criticize Baker's and Rhodes's arguments in order to get a better understanding of the relationship between the concepts of ME, CM, Professional Norms, and Moral Philosophy.

Before proceeding to the analysis, it is important to make a few initial clarifications. First, in relation to CM, it is important to distinguish between Beauchamp and Childress' conception of CM, and what could be called the "sociological common morality" (SCM). There is no doubt that many societies have a CM in the sense of an SCM. There is a set of moral standards that most of the members of that society will recognize as the right moral standards to which they will adhere to some degree. The SCM is unlikely to be universally shared in any society, but even those who do not share it will recognize its existence and will be able to specify its main elements. The SCM is not fixed, but is changeable over time, as is, for instance, illustrated by changes in sexual morality in many countries since the 1960s. Whether there is a global SCM is contested, but even if there is a global SCM, it differs from Beauchamp and Childress' CM

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in several ways. First, CM is defined not as a sociological discovery or set of empirical facts, but in terms of necessary moral commitment and universal applicability:

> "Some core tenets are found in every acceptable particular morality are not relative to cultures, groups or individuals. All persons living a moral life know and accept rules such as not to lie, not to kill or cause harm to others, to keep promises, and to respect the rights of others. All persons committed to morality do not doubt the relevance and importance of these universally valid rules. […]
>
> We call the set of universal norms shared by all persons committed to morality **the common morality**. This morality is not merely **a** morality, in contrast to other moralities. It is applicable to all persons in all places, and we appropriately judge all human conduct by its standards."[6]

Second, the content of a global SCM may not be consistent with Beauchamp and Childress' CM. One of the most recent and most extensive meta-analysis trying to identify a global SCM for instance argues that the norms that are shared across the 60 societies included in the analysis are essentially norms that enable and promote in-group social cooperation and that seven norms are identifiable:

> "(1) the allocation of resources to kin; (2) coordination to mutual advantage; (3) social exchange; and conflict resolution through contests featuring (4) hawkish displays of dominance and (5) dovish displays of submission; (6) division of disputed resources; and (7) recognition of possession."[7]

It may be possible to provide an analysis that shows that these seven norms are fully consistent with and can be derived from the four principles and five focal virtues of Beauchamp Childress' CM as developed in the eighth edition of their seminal book, but I submit that it will be difficult and require some significant argumentative contortions. We therefore have some reason to believe that if a global SCM exists, it will differ from the CM.

The second clarification is that, in this paper, the term ME will be used to denote the particular ethical principles and more specific ethical prescriptions that are, at any given time and locality generally accepted by the healthcare professions. In a modern healthcare system, this will involve the ethics of the medical and the nursing professions, as well as the ethics of any locally recognized "allied healthcare professions." ME may be formalized in professional codes of ethics, but the formalized codes only form part of ME, and may not reflect the most current understanding of the relevant HCPs. The modern healthcare context is multiprofessional with no single profession able to convincingly assert epistemic superiority across all aspects of healthcare, because all of the professions are now engaged in independent knowledge/evidence production. In the same way, no single profession can plausibly or justifiably assert exclusive or pre-eminent decisionmaking authority across all aspects of healthcare generally or in the case of all individual patients. There are many cases where, in the care and treatment of a specific patient no single profession can assert such authority justifiably across all aspects of the care and treatment.[8] These considerations entail that no single profession is justified in asserting its particular professional ethics to be pre-eminent in healthcare, and more specifically that the medical profession cannot justifiably assert the primacy of its particular professional ethics in the healthcare setting.

ME and CM

What is the relationship between ME and CM? There have been long-standing discussions about the relationship between CM or SCM and the specific content of ME, including whether ME can be deduced directly from CM or SCM. Even if such a deduction is possible, there is no reason to think that it is easy or straightforward, or that we will always get it right, since healthcare is a complex moral context. However, one corollary of the Beauchamp and Childress approach is that there can be no long-standing inconsistency between CM and ME, since ME is the properly reflective application of CM to the practice of healthcare. ME may, in its institutionalized form as professional codes of ethics be somewhat inconsistent with CM, but such divergence will be temporary and will be overcome in the long run.

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In her recent book "The Trusted Doctor" and in an article in the *Journal of Medical Ethics*, Rosamond Rhodes argues for the much more radical claim that there is no intrinsic connection between ME, that is the professional ethics of the medical profession (PME) and CM or SCM. PME is properly understood as a completely separate normative system with the content developed through reflection inside the profession. Rhodes summarizes her conclusion in the abstract of the JME paper:

> "This paper challenges the leading common morality accounts of medical ethics which hold that medical ethics is nothing but the ethics of everyday life applied to today's high-tech medicine. Using illustrative examples, the paper shows that neither the Beauchamp and Childress four-principle account of medical ethics nor the Gert et al 10-rule version is an adequate and appropriate guide for physicians' actions. By demonstrating that **medical ethics is distinctly different from the ethics of everyday life and cannot be derived from it**, the paper argues that medical professionals need a touchstone other than common morality for guiding their professional decisions."[9]

For reasons mentioned in the Introduction, I think that seeing the PME as separate or separable from, or more authoritative than the professional ethics of other healthcare professions is unjustified or misguided, but Rhodes' arguments, conclusions, and claims apply even to an enlarged multiprofessional ME.

Let us accept that there are many acts we allow or expect HCPs to do which we do not allow or expect ordinary people to do, and that there are certain virtues we expect HCPs to possess and certain vices they must not possess where we do not have the same expectations of others. This raises three questions: Does these acknowledged differences show that ME is distinctly different from "the ethics of everyday life" (which I take to be roughly equivalent of SCM)? If there is a distinct difference, does this show that ME cannot be derived from SCM? And, finally, if ME cannot be derived from SCM, who should decide the content of ME?

Let us briefly answer the third question first, since it is only tangential to the core question at issue in this paper, that is the relation between CM, SCM, moral philosophy, and ME. Rhodes answer is that we, as a matter of fact, allow the medical profession to decide the content of ME, because we trust the profession. And, that is as it should be as long as the profession stays trustworthy. As I have argued elsewhere, I think this is a mistake. Medical practice involves a dyadic relationship and neither of the participants in that relationship can claim epistemic or moral priority, and neither can lay claim to fully represent the interests of the other. Patients and doctors are both core stakeholders in relation to deciding the scope and parameters of the doctor–patient relationship, and both must be part of determining the ethics that should regulate the relationship (along with other important stakeholders)[10]. This conclusion is also supported by the consideration that it is always a bad idea to allow any profession to decide how its own conflicts of interests should be resolved. And, there are many conflicts of interest that arise for HCPs in their interaction with other actors and stakeholders in the healthcare context.

Is ME, then, distinctly different and nonderivable from SCM? We definitely allow HCPs to perform actions that we do not allow others to perform, even with the consent of the person on whom they are performed. Surgery and injections are perhaps prime examples. A recent UK Court of Appeal judgement, for instance, found, according to all accounts, a competent tattoo artist and body modifier guilty of causing grievous bodily harm in three cases of body modification, even though the three persons that had the modifications had sought out and purchased the services, had not complained, and had all given their consent.[11] We also give some HCPs powers in relation to compulsory admission and treatment that we do not give to others; we have special, complicated rules for medical confidentiality, and so forth. It looks like ME is distinctly different from SCM, and perhaps so different that it is nonderivable and *sui generis*. It is, however, important to note some peculiarities about these striking differences in permissions and obligations. The first peculiarity is that they do not attach in any straightforward way to the person as such, but to the person as an HCP. To take a trivial example, HCPs are supposed not to get angry with their patients, and it would be ethically wrong for a healthcare professional to show anger toward a patient even if he or she felt angry (except perhaps in extraordinary cases where "righteous anger" would be appropriate). But, HCPs are free to get angry at their family, friends, and the umpire that cannot see that the star player of their team has been fouled deliberately, and in the last case, they are free to shout at the television all they

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want. The second peculiarity is that some of the particular powers are very specifically legally circumscribed, and that the impetus for changes in the legal scope of these powers is often driven by developments in societal views and norms and not by the profession itself. The power to compulsorily treat psychiatric patients is, for instance, in many countries, only available if certain kinds of risk are present; and certain kinds of treatments are explicitly exempted from the scope of compulsion (e.g., electro-convulsive treatment and psychosurgery). These limits of the powers are not set by the profession, but by society.

This indicates that ME is not fully distinct from SCM, and that at least some elements of ME are not as a matter of fact decided by the healthcare professions.

It is also important to note that there are many other roles in society that also come with specific moral permissions and restrictions that do not conform to the general content of SCM. At one end of this spectrum, we have professional illusionists who are required as part of their occupational role to deceive their audiences, and required by their noncodified professional ethics not to divulge the techniques by which they deceive to anyone outside the profession. At the other end, we have the legal profession and the police with a wide range of moral permissions and restrictions that do not apply to others and are distinct from the SCM that apply to everyone, but which are not autonomously determined by the profession. The broad range of role specific moralities extant in and recognized by the society strongly indicates that the existence of role-specific moralities is a core component of SCM, and raises the question of whether ME can be derived from SCM as the role-based morality of HCPs?

If we look at this issue in the abstract, the question we would be asking is something like "Professional group P, has been allocated (or has developed into having) role R, which includes performing acts of type A that are not permitted or not required or both if performed by someone not belonging to P. What rules should apply to P when performing A as part of R?" To answer that question, we would need to understand both the role and the function of the role and the particular type of act, but how should we proceed to get from the factual knowledge and understanding of the issue and the context to an appropriate set of moral prescriptions? There is no doubt that it will be important to get input from the profession about its views on this, but equally obvious that SCM will come into play. Because if the rules applying to P when performing A as part of role R deviates from SCM it requires an explanation which provides a justification for the deviation. Part of that explanation is that the particular role R requires A to be done as part of the proper function of R, but that cannot be the whole explanation or justification. To take an example that is now historical in many countries, if we are told that it is right for HCPs to lie to cancer patients about their diagnosis and prognosis, and ask for justification of this claim, the answer "because the profession has decided that it is, after proper inter-professional reflection" is not a satisfactory answer. The justification will have to link up to general features of the conceptualization of lying and truth-telling in the SCM; and potentially also to whatever is taken to be the best or most persuasive philosophical account of obligations of veracity. ME as a professional ethics of a socially trusted and validated profession is necessarily partly derivable from SCM and moral philosophy, and could not be fully autonomous or autocephalic.

History, Philosophy, and ME

A second fundamental reconceptualization of how we should think about the development and consent of ME is offered by Bob Baker in "The Structure of Moral Revolutions."[12] Baker is well known as a historian and critic of bioethics[13] and in this new book, he presents an extended argument that ME and SCM does not develop through gradual evolution, but through a series of revolutions that are similar to the scientific revolutions famously described and analyzed by Thomas Kuhn.[14] A revolution in ME involves a paradigm shift and often a complete reversal of perspective on a particular set of ethical issues and/or on the values or scientific concepts that are seen as relevant. Baker's argument is both theoretical and built on a number of case studies. These include a study of the initial criminalization and later decriminalization of abortion and the role of the medical profession and medical science in this process, and a study of the emergence of bioethics as an at least initially patient-centered counter to internalized professional ME. According to Baker, the only way to understand the historical development and current

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form of ME is through a historical and sociological lens and through an acknowledgement that the history is punctuated by major disruptions. This is neither a history of continuous linkage to the past nor a history of gradual progress.

This entails that there is no link between CM and ME since there is no stable core of CM, and that although there is a mutual interplay between SCM and ME, the relation is complex. The interplay will be local and unstable in the sense that changes in SCM also follows a pattern of punctuated revolutions or disruptions which in areas of morality that are relevant to ME may have different temporal relations to revolutions in ME. SCM may lead the way, disruption may be simultaneous, or it may happen first in ME.

Baker's case studies are very detailed and strongly support his conclusion that the historical evidence shows that fundamental shifts and reversals occur in ME and in SCM. The question, however, remains how we should understand the role of philosophical reflection on ethics in these changes. Are they really best understood as Kuhnian revolutions, or is something else going on?

The first possibility is that the changes observed are not revolutions or tectonic changes in ethics, but revolutions that affect the empirical premises in ethical arguments. Most, perhaps all conclusions in ME build on arguments that include empirical premises of various kinds. These arguments are only sound, and perhaps more importantly for an account of historical developments only perceived to be sound, if the premises are (perceived to be) true. Let us return to the issue of truth-telling and lying in medicine. Until long into the 20th century HCPs routinely lied to patients with cancer about their diagnosis and prognosis,[15] and therefore, often also had to lie about the real reason for initiating certain treatments. At the same time, they might be truthful when talking to the patients' relatives. This approach to truth-telling in these situations is now seen as fundamentally wrong. Is this a revolution in ME? Did doctors suddenly one day wake up and realize that lying is wrong, truth-telling good, and veracity a virtue? Probably not. A much more plausible account of this particular reversal in ME is that important empirical premises in arguments about truth-telling have changed. Before the change, it was generally accepted that telling the truth to these patients would have (very) bad consequences and would therefore be both counterproductive and cruel. After the change, it is generally accepted that being truthful in this context has good consequences for patients because it allows them to act on the knowledge. When the ethical norm sediments in ME, it becomes detached from the underlying argument and its premises and becomes a pure, isolated ethical prescription "Do not lie to cancer patients!" Thus, we end up with what looks like a revolution in ethics, but is really a change in what we believe is true about the world and the effects of our actions in the world.

A distinct and important instance of change in premises leading to simultaneous change in SCM and ME is the effect of secularization and the concomitant loss of religious/theistic premises that are traditionally fundamental to core areas of ME. We may not initially conceptualize theistic premises, for example about the existence of God as empirical, but for the ordinary, nonphilosophically trained believer they are empirical in the sense that they are seen as truth-apt propositions with a value that ultimately depends on an empirical fact, that is the existence or nonexistence of God. Secularization entails that the perceived truth value of these theistic premises is reversed, and that the moral and other arguments that depend on them therefore are perceived as unsound. This has already led to "revolutions" in ME in relation to reproduction and end-of-life issues in some countries. These are not yet completed revolutions, still in progress in the sense that the full implications of the reversal of the perceived truth-value of theistic premises have not yet worked its way through the system of ME or of medical laws.

The second possibility is that theoretical developments in ME lead to new arguments leading to new conclusions that are (seen to be) compelling. That is, there is no revolution but just the normal often tedious and slow development of philosophy, in this case, moral philosophy, by analysis, argument and counterargument. This is in many instances compatible with the Kuhnian account. Just as there are long periods of "normal science" with incremental development in between scientific revolutions and their attendant scientific paradigm shifts, there can presumably be "normal ethics" in between moral revolutions. An example could be the still ongoing discussions in bioethics about the precise justification, content, and implications of the generally recognized principle that informed consent is an (almost) necessary condition for participation in medical research. These discussions have never ceased in the academic literature after informed consent became a cornerstone of research ethics in the 1960–1970s

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and some of the subtle changes in argument and conclusions have over time influenced the more sedimented, official or semi-official enunciations of this principle in declarations, regulations, and other normative documents. However, *contra* Baker there also seem to be examples where critical philosophical argument is the driver of at least "mini revolutions," that is, reversals of firmly held positions in ME. Showing this in detail would probably require a book length project like Baker's and extensive expertise in medical history. So, here I will just gesture at some possible examples. The first example is in reproductive ethics where simplified versions of Derek Parfit's nonidentity problem[16] have played a significant role in reversing the presumption that the welfare of the child created by the use of assisted reproductive technologies (ARTs) should be a paramount consideration in determining who should get access to ARTs and what limits should be set for the reproductive projects that can be pursued through ARTs. The second is the role that Alan Wertheimer's analysis of mutually beneficial exploitation and his more general work on exploitation and coercion[17] has had in some very prominent strands of discussions in the United States of international research ethics in relation to placebo-controlled trials in low- and middle-income countries. It could be argued that these examples are not really examples of reversals, ruptures, or revolutions, because they are too 'localized' to a small area of ME. However, there are also plausible examples of philosophically driven more global revolutions in ME. The most important of these is probably the very emergence of bioethics in the sense of a critical engagement with the ethics of healthcare that is not confined to internal reflection within the healthcare professions. This historical event or process can be described and analyzed in many ways and we certainly have to be careful not to write a Whig account of history,[18] where, say the concept of respect for the autonomy of patients became all conquering simply because of its philosophically justified, compelling persuasive power. But we should not write a deflationist story either. Bioethics could not have emerged without antecedent and concurrent changes in society and in the professions making space for the "strangers at the bedside,"[19] but it could not have emerged either without the antecedent return from a focus on meta-ethical issues like the meaning and function of moral words to a focus on normative and applied issues in Anglo-American academic philosophy. And, the particular form that bioethics eventually acquired in the affluent English-speaking countries as an academic-practical hybrid owes just as much to developments in academic philosophy as to developments in society and the professions.

Conclusion

This paper has obliquely argued for two main conclusions. The first is that CM and ME are intertwined, and that although ME is distinct as the ethics of a particular set of societal roles, it is not (and should not be) autonomous. The second is that moral philosophy and ethical theory matter in the evolution of ME. This evolution is punctuated by revolutions and reversals and cannot be understood as a smooth incremental development toward progress. However, some developments that look like revolutions in ethics are best understood as revolutions in views on factual matters, other revolutions are primarily occasioned by developments in moral philosophy and ethical theory, and others are driven by changes in SCM that first occurs outside of the healthcare context, but later impinges on ME.

This does not mean that we can deduce ME from ethical theory, either at the level of principles or at the level of specific judgments in a way that will compel someone to accept the validity and soundness of our deduction. We do not agree about what the correct ethical theory is and there is room for reasonable disagreement about this. This entails that some foundational premises will be recognized as true by some reasonable and reflective people and deemed to be false by other equally reasonable and reflective people. So, the soundness of our moral arguments is often uncertain, even when they are logically valid. Furthermore, the chains of deduction are very often too long and contain too many steps and premises for us to be certain that the deduction is logically valid; and this is even before we consider the issue that there are several competing ways of formalising deontic logic.

As argued above ME is, however, also a social construct in the sense that it regulates the relations and interactions between a specific set of professionals, their patients/clients, and society in general. This has the consequence that although ME can diverge from the general ethical views in a particular society, that

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is CM in the sociological sense, it cannot diverge significantly in the long run unless the divergence can be given a justification that is perceived as acceptable in CM. ME itself is not static either. The continued moral reflection of the professions, the development of new forms of treatment raising or highlighting particular ethical issues, the changes in the organization of healthcare, the entry of new cohorts and types of professionals, and so forth all interact to create a situation where ME will evolve and change over time. Some of these changes will then engender change in the SCM. From this it follows that there can be major changes, perhaps even revolutions in ME. These can be driven by external developments in the SCM, by internal developments in ME, by development in moral philosophy, or in most cases by the complex interplay of these factors in an ever-changing world.

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