Cambridge Quarterly of Healthcare Ethics (2022), 31: 2, 161–162
doi:10.1017/S0963180121000554

CAMBRIDGE
UNIVERSITY PRESS

EDITORIAL

Common and Uncommon Moralities in Bioethics: Yet Another Final Countdown

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The role, and indeed the very existence, of common morality has been a contested matter in bioethics since the dawn of the discipline. The publication of Robert Baker's *The Structure of Moral Revolutions: Studies of Changes in the Morality of Abortion, Death, and the Bioethics Revolutions*[1] and Rosamond Rhodes' *The Trusted Doctor: Medical Ethics and Professionalism*[2] sparked these debates anew. This collection of articles, many of which originate in the Symposium on Common Morality, Solidarity, and Trust at the 15th World Congress of the International Association of Bioethics in June 2020, brings together some of the most renown experts in the field to tackle the question.

The *Principles of Biomedical Ethics* is arguably not only the most influential book in bioethics, but also a paragon of common morality-based bioethics theories.[3] It is, therefore, fitting that the section opens with a contribution by James F. Childress and Tom L. Beauchamp. They briefly sketch the common morality basis of their theory before responding to the criticisms presented by Rhodes and Baker, respectively. They offer several arguments against Rhodes' position, which entails that professional medical ethics is distinct and radically different from common morality. The bulk of the criticism is grounded on what Childress and Beauchamp perceive as Rhodes' misunderstanding of common morality, but they also point to the internal problems they see in Rhodes' theory. Although Rhodes does not discuss the existence of common morality as such—she just maintains that professional medical ethics is separate—Baker holds that common morality is a fiction, and that theories based on it are not only necessarily faulty, but also dangerous. Similarly, in their response to Rhodes, Childress and Beauchamp maintain that many of the issues Baker has with common morality are based on misunderstanding on how principlism works.[4] In addition, they question Baker's lenience toward human rights discourse as the criticism he has presented against common morality seems to be equally applicable there.

Ruth Macklin made a significant contribution to the common morality discussion with her 1999 book *Against Relativism: Cultural Diversity and the Search for Ethical Universals in Medicine.*[5] Here, she offers a more focused defense of common morality by concentrating on the issues brought to the fore by the recent books of Baker and Rhodes, namely the role of human rights and the possibility of a distinct medical ethics. She maintains that human rights and common morality are both ideal attempts to capture universal ethics, but that neither is more "ideal" than the other and that medical ethics cannot be separated from the universal ideals. As an illustration, she uses the COVID-19 pandemic and responses to it to show how common morality is, contrary to Baker's position, globally applicable. And further, it is applicable to ordinary people and the medical profession alike, which counters Rhodes' main stance.

In his article, Peter Herissone-Kelly is looking for a way to uphold common morality in the face of the many apparent counter-examples to its alleged global applicability. He uses the Buddhist culture, which holds nonmaleficence in high regard, but to which the notion of autonomy is completely alien, as an example. His analysis shows how the various strategies that the defenders of common morality could choose fail. Consequently, Herissone-Kelly sees only one possible route to salvage common morality. According to him, only by accepting a nonrealist view of the common morality's principles can common

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https://doi.org/10.1017/S0963180121000554 Published online by Cambridge University Press

morality adequately respond to its critics. He, however, doubts as to whether this is a position the defenders of common morality would be comfortable with.

The recent books by Baker and Rhodes prompted Søren Holm to study the relationship between common morality, "sociological common morality," medical ethics, professional norms, and moral philosophy. In response to Rhodes' thesis, he argues that medical ethics is not and should not be separated from common morality. He then proceeds to analyze Baker's claim that medical ethics has evolved, and evolves, through Kuhnian revolutions. Although Holm agrees that Baker presents strong evidence of fundamental changes in medical ethics, he argues that the mechanisms of the paradigm changes do not follow the logic of Kuhnian revolutions, but involve a more complex interplay of various factors.

In his response, Robert Baker reattests his critique of the *Principles of Biomedical Ethics* and its reliance on common morality. He recognizes four main features on which the common morality theories can be challenged. The theories are: (1) unfalsifiable, (2) unempirical, (3) artifacts of a category mistake, and (4) useless for analyzing moral change. Since (1) and (2) have been extensively discussed in the literature, he concentrates on (3) and (4). He uses killing as the main example of the category mistake by showing how, although it is true that throughout history societies have commonly regulated killing, their common regulations as to who can be killed and under which circumstances have varied so widely that talking about common morality is unwarranted. His main issue with common morality seems to be, however, its inability to see historical and current moral diversity for what it is. This, he believes, makes us unable to respond effectively and address the moral challenges that await us.

This section closes with Rosamond Rhodes' response to Childress, Beauchamp, Macklin, and Holm. She concentrates on their worry that her model isolates medical ethics from societal input and results in an ethics created by professionals for the professionals. She feels that her critics have not fully understood her position regarding the relationship between the medical profession and society and proceeds to clarify her views on that. According to Rhodes, there actually is very little tension between medical ethics and what she calls everyday ethics. And further, neither of them has any priority or authority over the other. These two are distinct, but because medical professionals are only allowed their powers, privileges, and immunities as long as the society grants them those, society's ethical views cannot be too different from those of the medical professionals. Her assertion of an autonomous ethics for medical professionals arises from the expertise and experience of the professionals, which, according to her, make them the only people qualified to formulate the ethics of the profession.

Acknowledgments. Our thanks are due, for financial support, to the Academy of Finland (project Bioeconomy and Justice, SA 307467) and the Finnish Ministry of Agriculture and Forestry (projects The Role of Justice in Decision Making Concerning Bioeconomy 101/03.02.06.00/2018 and A Just Management Model for Systemic and Sustainable Shift Towards Bioeconomy 2142/03.02.06.00/2018).

Notes

1. Baker R. *The Structure of Moral Revolutions: Studies of Changes in the Morality of Abortion, Death, and the Bioethics Revolutions*. Cambridge, MA: The MIT Press; 2019.
2. Rhodes R. *The Trusted Doctor: Medical Ethics and Professionalism*. New York: Oxford University Press; 2020.
3. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*. 8th ed. New York: Oxford University Press; 2019. The idea of common morality has been explicit in the book since the 4th edition.
4. Childress JF, Beauchamp TL. Common morality principles in biomedical ethics: Responses to critics. *Cambridge Quarterly of Healthcare Ethics* 2022; **31**(2):164–76. doi:10.1017/S0963180121000566.
5. Macklin R. *Against Relativism: Cultural Diversity and the Search for Ethical Universals in Medicine*. New York: Oxford University Press; 1999.

Cite this article: Häyry M and Takala T (2022). Common and Uncommon Moralities in Bioethics: Yet Another Final Countdown. *Cambridge Quarterly of Healthcare Ethics* 31: 161–162, doi:10.1017/S0963180121000554

https://doi.org/10.1017/S0963180121000554 Published online by Cambridge University Press

Various male and female votive heads. Terracotta (6th-5th BCE), unknown origin.
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