

1981

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Recommended Citation

Martin, Mike W. "Rights and the meta-ethics of professional morality." *Ethics* (1981): 619-625.

DOI:10.1086/292274

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This article was originally published in *Ethics* in 1981. DOI: [10.1086/292274](https://doi.org/10.1086/292274)

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University of Chicago Press

Rights and the Meta-Ethics of Professional Morality

Mike W. Martin

In "A Meta-Ethics for Professional Morality," Benjamin Freedman contends that professional morality requires deviations from what ordinary morality prescribes.¹ Moreover, it is impossible, he avers, to provide a deontological justification for these professional norms. They must be defended instead in terms of society's approval of the fanatical pursuit of ideals by professionals. I will argue that Freedman's defense of these views is inadequate. Using his own example of confidentiality, I will then illustrate the appropriate role that deontological considerations operating in ordinary morality—namely, rights—play in justifying the special moral norms of the professions.

I

Freedman develops his arguments using medical confidentiality as the central illustration. His argument for why professional morality conflicts with ordinary nonprofessional morality may be set forth as follows. (1) The obligation to maintain confidentiality is a central tenet in the professional morality of physicians (as well as that of doctors, priests, engineers, etc.). (2) Medical confidentiality differs in two respects from ordinary confidentiality. First, it automatically covers all information given to the doctor as well as what the doctor discovers in the course of treatment, without the need for ordinary explicit indicators by the patient that the information is to be held confidential. Second, it is a much stronger moral requirement than the ordinary moral requirement to maintain confidences. That is, the physician's obligation to maintain confidences can be overridden only by reasons much more serious than those required to override the ordinary obligation to maintain confidentiality on matters of similar importance (pp. 2-3). (3) Hence, medical confidentiality licenses different and sometimes contradictory conclusions from those of ordinary confidentiality. (4) Therefore, medical confidentiality and professional morality license deviations from what ordinary morality prescribes: "On the basis of professional morality we may arrive at a practical conclusion not countenanced (in any straightforward way) by ordinary morality" (p. 4).

1. *Ethics* 89 (1978): 1-19. Numbers in parentheses are page references to Freedman's article.

Ethics 91 (July 1981): 619-625

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Premises 1 and 2 are true and lead to 3. As Freedman correctly points out, appeal to best consequences is more readily allowed as justification for breaking ordinary confidences than it is for medical confidences. Without a patient's authorization a doctor cannot divulge even innocuous medical facts unless very serious likely harm to the patient or others is involved. The increased seriousness of medical confidentiality is formally indicated by its protection by laws.

But 4 does not follow from 3. The mere fact that the medical confidentiality obligation requires acts conflicting with what the ordinary confidentiality obligation sanctions does not establish that professional morality justifies deviations from what ordinary morality prescribes (even assuming that the medical obligation is, in fact, morally valid). For there may well be other ordinary moral considerations which explain why the medical obligation is stronger. These considerations, of course, will have to take into account the circumstances of medical practice. In this sense, they will be ordinary moral considerations applied to the special or 'non-ordinary' context of professional dealings. I will argue later that moral rights constitute just such considerations—that there are ordinary moral rights which require especially strong reciprocal obligations when viewed within the context of medical and other professional relationships.

Freedman's deceptive argument, we might note, is a type of composition fallacy having the following general construction:

One aspect of ordinary morality (e.g., the ordinary obligation to maintain confidences) is not as strong as its analog in professional morality (e.g., the professional obligation to maintain confidences). In fact, the professional norm may license acts which violate its analogous ordinary moral norm. Therefore, the system of professional morality sanctions departures from the system of ordinary morality.

The fallacy lies in moving from claims about the relationships among parts of the systems of professional and ordinary morality to claims about the two systems themselves. It disregards the possibility of there being other elements in ordinary morality which justify departures from the one element under consideration.

II

Freedman presents two arguments against a deontological justification of professional moral norms. Both of them are formulated against a specific version of deontology which would ground these norms in a promise, a version which I will refer to as the Promise View. The first argument is as follows:

Given that professional ethics differs from and is in conflict with ordinary ethics, . . . by promising to obey professional morality, one has promised to contravene ordinary morality; and a promise to perform evil is traditionally regarded as either not binding at all or

as deficient in its binding power. . . . But the promise to adhere to professional morality is just such a promise to do evil from the very outset, that is, a promise to accept an ordering of values different from that afforded by nonprofessional morality. [P. 12]

The argument turns on conflating the very different notions of “contravening ordinary morality” and “doing evil.” Throughout the essay, Freedman uses the expression “ordinary morality” as a mere contrast for “professional morality”; yet the contrast should be nonprofessional morality, or, better put, a morality considered apart from the specific moral obligations of professionals. Given this usage, there is no warrant for equating departures from ordinary moral obligations with doing evil in the sense of acting immorally, but quite the contrary. Freedman himself argues at length that such departures are justified. But if special professional responsibilities are justified, then the Promise View cannot be refuted by viewing the professional’s promise as a vow to do evil.

The second argument is a *reductio ad absurdum* that begins by assuming (for the sake of argument) that a promise could justify adherence to professional moral norms (pp. 12–13). Using a series of rhetorical questions, Freedman claims that the promise to adhere to professional norms will be overridden at every point where ordinary morality seriously contradicts it; hence, ordinary and professional moral norms cannot seriously conflict. But it has already been established that they can, and therefore the Promise View entails a falsehood and must be rejected.

As it stands, this argument again illicitly equates violations of ordinary obligations with wrongdoing. That is, without warrant it forces the defender of the Promise View into viewing ordinary moral obligations as stronger than (i.e., always overriding) professional obligations.

Nevertheless, the argument can be revised to make it more compelling. Instead of saying the promise would have to be overridden every time it conflicted with ordinary obligations, Freedman should have said that the Promise View provides no answer as to whether professional norms ought to be overridden when they conflict with ordinary moral norms. That is, for all the Promise View says, the obligation created by the promise *might* be constrained at every juncture where it conflicts with ordinary morality. Hence, the Promise View cannot by itself provide a justification for professional obligations.

The point can be put even more straightforwardly. A mere promise to abide by medical mores cannot justify those mores, for in general a promise cannot by itself justify abiding by any given set of mores. This is because the mores, for all the promise says, may be unjustified on their own merits and may sanction gross immorality. Taken by itself, the Promise View is not even a serious candidate for justifying the content of professional norms.

If Freedman had been clearer about why the Promise View should be rejected, perhaps he would have cast about for alternative deontological positions. Instead, he quickly generalizes that his two arguments cut

against any deontological approach to justifying professional norms: "For deontology, either the immorality [that professional norms may lead to] is real—in which case one cannot bind oneself to it—or it is (merely) apparent—in which case we do not have the requisite conflict" (p. 13). This begs the question as to whether other deontological considerations, such as rights, may be candidates for justifying professional norms, which would then permit professionals to bind themselves to them by a promise, oath, or the mere adoption of a particular social role. With respect to confidentiality, one such candidate is well known: the patient's right to privacy.

III

Having rejected deontological approaches, Freedman correctly dismisses act-utilitarianism. The confidentiality obligation in both ordinary and professional morality rules out as illegitimate the making of exceptions every time the consequences of doing so seem slightly better. On the surface, rule-utilitarianism is a much more plausible alternative. It asserts that the rule of maintaining confidences promotes patients' trust and hence their willingness to divulge private information relevant to their therapy. Thereby, it serves to produce the good consequences of successful therapy and good health.

Freedman is hesitant to adopt this familiar rule-utilitarian move. He poses doubts as to whether ultimately it may be reducible to unacceptable act-utilitarianism. More importantly, he questions whether there are good reasons for thinking medical confidentiality does produce the maximal good consequences even in terms of effectively protecting health. He thus is led to offer a novel solution to the problem.

Professionals, he says, are fanatically committed to pursuing ideals which help them achieve their central professional goals (at least, by their view of means-to-end relations). Physicians, for example, are "zealots for health" (p. 14). They subscribe to the ideal of *primum non nocere*—above all do no harm (to the patient)—so they emphasize confidentiality, which they view as promoting successful therapy. We, as the general public, approve of at least some professional zealotry in pursuing such ideals as promoting health, for we stand to gain by it in certain respects. For this reason we recognize as legitimate the norms which enable professionals to achieve their ideals: "By our desire that physicians be zealots for health, we must allow its corollaries" (p. 14).

This ingenious argument can serve as a psychological explanation for why we countenance professionals operating by their own norms. But it does not provide a moral justification of those norms. For it leaves unanswered the question of whether our desires for professional zealotry are morally reasonable, all things considered. A rule-utilitarian, for example, might respond that, insofar as there are doubts about whether a given professional norm maximizes good consequences, the same doubts carry over to whether the public's indulgence of the norms is rational. We

may agree that “society ought to, and does, [sometimes] grant freedom to those with fanatical adherence to an ideal” (p. 14). But when that ideal comes into conflict with other ideals, some independent moral reasoning might have to be invoked to resolve priorities. Freedman’s Ideal Theory is just like the Promise View in failing to provide moral justification for the specific content and limits of professional obligations.

IV

It is time to sketch an alternative deontological approach for justifying professional norms, focusing on the example of professional confidentiality in medicine. As already indicated, the appeal to rights, and in particular privacy rights, is familiar in this context,² and one wonders why Freedman failed to give it even passing mention. Perhaps it was owing to what A. I. Melden recently called attention to as philosophers’ general preoccupation with ‘oughts’ and obligatory acts, to the neglect of rights.³ Engrossment with the fact that professionals acquire special moral obligations can lead one to exaggerate the differences between ordinary and professional morality. The sole connection that Freedman notes is the injunction in ordinary morality to honor acquired professional obligations (p. 6). But this tenuous link belies deeper interrelations deriving from moral rights.

In any case, my concern is to illustrate how ordinary moral rights—that is, rights operating in ordinary morality—can be invoked to explain both the role attachment and the special stringency of professional obligations. In addition, I will urge that only the notion of rights can do justice to the felt personal nature of many of those obligations. For the confidentiality obligation is an obligation to a given patient (or penitent, employer, etc.) rather than some general obligation to society at large or to future patients.

Let us begin by recalling several familiar cases of confidentiality, some involving professional relationships, which derive from specific acts of entering into a confidence rather than from roles. (a) A government official entrusts me with secret information concerning a scientific project I am pursuing. He would never find out that it was I who revealed the information to foreign spies, and hence I may not bring harmful consequences to him, but my act might have dangerous ramifications for national security. (b) My boss reveals to me in confidence the details of our company’s new bid. If I pass this information on to our competitors I will be undermining his authority, insulting him by failing to respond to the

confidence he placed in my honesty, and doing harm to the company. (c) A close friend confides in me that he is having serious marital difficulties. Broadcasting this about the neighborhood would violate and perhaps destroy our friendship. (d) A colleague nearing the tenure decision confides in me that he is unhappy with his work and is sending out his resumé without telling the college administrators. If I told the administrators, I would be showing utter disrespect for a colleague as well as possibly influencing negatively the tenure decision.

Freedman says at one point that, beyond its frequent good consequences, much of the value of confidentiality lies in its intrinsic worth as an "immediate affirmation of a particular kind of human relationship"—viz., the relationship of trust (p. 13). The cases illustrate this, but also indicate how relationships of trust may be embedded within contexts involving other sorts of valued relationships: loyalty to country, respect for legitimate authority, friendship, mutual respect among colleagues. The cases can also be used to illustrate how the person who confides the information has special authority to decide whether it shall be passed on, an authority explained by ascribing a moral right to determine that the information remain confidential. In the last two cases the right is specifically a right to have personal information kept private within boundaries set by the person himself. The friend and the colleague have the right to have the information kept confidential when revealed with that understanding. The first two cases involve the rights of the government representative and the employer to decide who shall have access to important government or company information.

Consider now the obligation of professionals, doctors in particular, to maintain confidentiality. We need to answer three questions: (1) Why do special obligations of confidentiality become attached to professional roles, such as that of being a physician? That is, why do the obligations apply to all information of a certain type obtained in the course of functioning in that role without the need for any explicit requests for confidentiality by patients? (2) Why are professional obligations of confidentiality more binding and forceful than ordinary ones, where information of similar importance is involved? (3) Why is the confidentiality obligation owed to specific individuals, such as the specific patient, rather than to the general public or merely to future patients who must be able to trust the doctor? The answer to all these questions is that patients have special rights to have their medical information kept confidential, and their general rights to privacy have special importance in the medical context.

A number of considerations combine to make the right to privacy have special force in the medical context and apply to all medical information. (a) Medical information is often extremely personal, especially psychiatric information. If there is any area where a person has a right to determine what shall be revealed to whom, it is here. (b) The patient is in an especially vulnerable position with respect to the doctor upon whom he or she must rely for help. There are special needs for safeguards to

protect the patient. (c) The patient's health and life is at stake in being able to openly convey information to the doctor without an inhibiting anxiety that the information may be misused. (d) There is always uncertainty as to how medical information may be misused. Because of its general importance, only a general ban on revealing it can maximally protect patients' rights. (e) The doctor is providing a service which the patient pays for directly or through insurance (and pays dearly!). The transaction of information involved is part of the service, which the patient has a right to control within limits.

V

There remains space for only three final comments. First, no right is absolute in the sense that it cannot be overridden by other moral considerations. In particular, the right of a patient to confidentiality will at times have to give way to considerations of greater public good. Second, there is no question that if doctors freely divulged personal information about patients medical practice would then be harmed. The loss of trust would lead patients to be wary of divulging highly personal information to doctors, even though the information was directly germane to restoring their health. But the fact that such rule-utilitarian considerations play some role in justifying medical confidentiality does not preclude other deontological justifications. We need only note that the patients would lose trust *because* they saw how doctors disregarded their moral rights.

Third, the invocation of particular rights always carries with it an ad hoc air until they are grounded in fundamental human rights. I believe the privacy right can be given a grounding in the basic right of an agent to pursue his or her legitimate interests. The right to confidence owned by a patient, penitent, defendant, or employer, vis-à-vis a physician, priest, lawyer, or employed engineer, is grounded in the agent's right to freely pursue legitimate affairs. The details of showing this would require another occasion, but I believe the argument can be worked out along the same lines Melden uses in *Rights and Persons* to ground the right bestowed by a promise.