PROFESSION AND PROFESSIONAL ETHICS

Among any society's most important institutions are the social structures by which the society controls the use of specialized knowledge and skills. This fact is particularly true when highly valued aspects of human life depend on such expertise, and all the more so if acquiring such expertise requires lengthy theoretical education and intensive training in its practical application under the supervision of those already expert, thus rendering the valuable knowledge and skills unavoidably exclusive.

Social control over the use of such knowledge and skills is important because the members of the expert group could use their exclusive expertise solely for their own benefit or even hold society hostage to their expertise. But those who might exert such control, if they are outside the expert group, cannot depend on their understanding of this expertise because they lack precisely the relevant knowledge and practical training. How, then, can a society control the use of important, specialized expertise and render those outside the expert group secure that they will be able to enjoy the values that depend on it? One of the most important social structures developed to this end is the institution of profession.

A few social philosophers and a large number of sociologists, following Emile Durkheim and Talcott Parsons, have studied the institution of profession in depth and have attempted to identify its essential elements. This task is not a simple one because so many groups have been eager to appropriate the title of profession in order to enjoy the social rewards that go with it. In addition, the terms "profession" and "professional" have both normative and descriptive uses in ordinary discourse. Nevertheless, by looking for common features among the most obvious examples of this institution, such as medicine, law, and dentistry, a useful listing of characteristic features of the institution of profession is available.

The key features of a profession

Important and exclusive expertise. For an occupational group to be a profession, it must provide its clients with something the larger community judges extremely valuable, either because of its intrinsic value or because it is a necessary precondition of any person's achievement of valued goals, or both. Health and the preservation of life, to take two commonly identified goals of the health professions, are held by almost everyone to be values of the highest order, either as intrinsic values or as necessary preconditions of people's achievement of whatever else they value. In a similar way, security of one's property and person against the errors of others and against the adverse workings of government and the legal system, as one defensible description of the goal of the legal profession, is also widely valued as a precondition of achieving whatever other goals one has.

The expertise of a profession has both cognitive (theoretical and factual) and practical (the fruits of experiential learning) components that are of sufficient subtlety and complexity that only persons who have been specifically and extensively educated in them, by persons already expert, can be depended upon to bring about the relevant benefits for the occupation's clients.
In the practical division of a society's labors, this makes possession of such expertise exclusive to a relatively small group. Moreover, for the same reason, only persons fully educated in both knowledge and practice of a profession's expertise can be relied on to judge correctly the need for expert intervention in a given situation, or to judge the quality of such an intervention as it is being carried out. Judgments of need and judgments of the quality of the expert's performance by those not so trained are not dependable. Because of the importance of what is at stake, it is not sufficient to judge the performance solely on the basis of its long-term outcomes, even when the nonexpert can accomplish such a judgment unaided. Long-term outcomes will not be known for some time, and the risk of negative consequences in the meantime, in a matter of great importance, means that delayed judgments are simply not enough.

The expertise of a profession involves not only specialized and complex knowledge, both theoretical and practical, but also the application of this knowledge. This is the reason that mastery of a profession's expertise requires experiential as well as cognitive education. This is also why the members of a profession are said to "practice" its expertise. A profession is not made up simply of experts; it is made up of practitioners of a body of expertise.

Internal and external recognition. A profession, as an occupational group made exclusive by reason of its particular body of expertise, is also characterized by a set of internal relationships of which the most important is a mutual recognition of expertise on the part of its members. These internal relationships may be quite informal or may become quite formal, as when a community of experts who mutually recognize each other's expertise establishes a formal organization. The expression "the profession of medicine" thus refers most properly to all those expert in the practice of medicine, mutually recognized as such by one another, within whatever geographic limits are relevant. This same expression is also used, however, to refer either to the chief national organization of such persons, the American Medical Association (AMA), or to some larger set of associations, including the AMA, to which physicians would be likely to belong. However, it is not the formal character of association among experts, but the fact of their mutual recognition of expertise, that is most important here. Other expressions—for example, "organized medicine"—are available to refer to formally constituted groups.

The expertise of a profession is not only mutually recognized by those who possess it; it is also recognized by the members of the larger community. Because of the exclusive nature of professional expertise and the importance of its application, such external recognition is most often expressed in formal actions of the larger community, such as certification, licensure, and so on, that confer formal authority over the profession's expertise. A profession may receive, for example, exclusive authority both to determine the degree of expertise needed by those who intend to practice it and to test the expertise of those who claim to do so. Since students of the profession must undertake lengthy and specialized training in order to master its expertise, the larger community's authorization is likely to include a grant of exclusive authority to train and certify new members of the profession. But, as with internal recognition, it is not the formal character but the reality of external recognition that is essential to the character of a profession.

Autonomy in practice. Because the activity of a profession is so valued by its clients, and because proper performance and dependable judgments about performance depend upon expertise that is unavoidably exclusive and therefore not available to the ordinary person, a profession's clients routinely grant its members extensive autonomy in the actual performance of the profession's practice. The term "autonomy" has a number of important uses in moral discourse and often appears when issues in bioethics are under discussion. Here this term refers specifically to the acceptance by clients of the professional's judgments as determinative on any matter that is within the range of the professional's expertise. Such autonomous judgments by professionals arise in three possible arenas.

The first area, autonomy in practice judgments, depends on the assumption that each member of the expert community possesses the relevant professional expertise and is therefore a dependable provider of its benefits. It includes three elements: first, determination of the specific needs of the client in matters within the range of the professional's expertise; second, determination of the likely outcomes of various courses of action that the client, the professional, or some other party might undertake in response to these needs; and third, judgment of which of the possible courses of action is most likely to best meet the client's needs.

Consider, for example, the encounter between a physician or a dentist and a patient. The patient often accepts without question the doctor's judgments regarding the nature of the patient's present condition and of the patient's need for care, if any; the range of courses of action that might be taken in response; and the likelihood that one of these courses of action will best meet the patient's needs.

A fourth possible element of professional autonomy may consist in judgments about the intermediate, instrumental steps appropriate in carrying out the chosen course of action. Although these judgments are often carried out by the professional as well, they can be and frequently are relegated to another party, such as a tech-
tician. Such a person, while capable of making judgments about properly applying instrumental actions already identified as needed, is not necessarily capable of judging dependably regarding the need for these actions.

In some circumstances, the instrumental actions needed to respond to the client's situation may depend, like the original judgment of the need for them, upon exclusive expertise. In such cases, the "prescribing" professional may need to refer the client to another professional to have the needed intervention carried out. In this situation, further judgments of need, identification of outcomes, choice of a best course, and choice of instrumentalities are carried out over a much narrower range of alternatives by the specialist to whom the client is referred.

Although each individual client grants autonomy to the professional, clients do not ordinarily do so simply on the basis of their individual judgments of the expertise of the individual professional. They make their judgments rather on the basis of a more complex set of factors involving the community's (external) recognition of the professional group's expertise and the professional group's (internal) recognition of the expertise of the particular professional. Thus, even though this grant of professional autonomy takes place above all between the individual client and professional, its full meaning can only be understood against the background of the institution of profession.

Second, the professional's ability to serve clients by making dependable judgments is often conditioned in turn by various features of the situation in which the client-professional encounter takes place. In order to assure that professionals' judgments are as dependable as possible, professionals often seek, and the larger community and individual clients often grant them, considerable additional autonomy to determine the immediate circumstances of practice.

The extent of this aspect of professional autonomy depends on answers to two questions. What aspects of the immediate circumstances of practice significantly affect the quality of professional performance? And what additional factors do members of the profession also prefer to control, at least for their convenience and perhaps also out of a conviction, which may be unexamined or even mistaken, that they affect the quality of professional performance?

For example, physicians, not their clients, control the daily routine of medical practice. In the marketplace, this control could easily be explained as the producer's control of the product he or she offers. But physicians ordinarily justify such preferred patterns of practice on the grounds that this is the best way to serve all their patients; patients, in turn, ordinarily change their daily schedules accordingly, though many may be doubtful that the inconveniences they accept really are the only way that physicians can best serve all of their patients.

Third, a professional's ability to serve clients by making dependable judgments is also conditioned by other, broader parameters over which professionals may seek, and the larger community may grant, some measure of control. To an even greater degree than autonomy in making practice judgments and in controlling the immediate circumstances of practice, autonomy of this third kind is ordinarily granted to the members of a profession as a group rather than individually.

Physicians' opposition to health-insurance programs in an earlier day, for example, and their later opposition to federally funded health-care programs for the needy were remarkably effective in preserving the medical community's preferred (at that time) economic structure for health-care distribution, namely, the fee-for-service marketplace. At one time, physicians also exercised almost total control over hospitals in the United States. Their consistent rationale—whether correct or not—was that such economic and institutional arrangements as they preferred were the most likely to produce the best health care for their patients; the larger community generally accepted this rationale as an appropriate reason for physicians to try to control health-care economics and health-care institutions.

Other forms of expertise have since been accepted as much more important than medical expertise to health-care economics and health-care administration. Consequently, physicians' autonomy in these areas has been much curtailed since the 1970s. Of course, physicians' reasons for preferring one economic or institutional arrangement rather than another will almost always deserve consideration when broader social and institutional parameters do impact the quality of care they can provide to patients. But this third category of autonomy does not appear to be central to what a profession is.

Professions' and professionals' obligations. The final and, for present purposes, the most important feature of the institution of profession is that membership in a profession implies the acceptance by its members of a set of norms of professional practice. To make this point clear, contrast what may be termed a "normative" picture of a profession with what may be termed a "commercial" picture.

According to the commercial picture, practicing a profession is no different in principle from selling one's wares in the marketplace. According to those who take this view, the professional has a product to sell and makes the appropriate and needed agreements with interested purchasers. Beyond some fundamental obligation not to coerce, cheat, or defraud others, the professional would have no other obligations to anyone
except those voluntarily undertaken with specific individuals or groups. According to the commercial picture, in other words, there are no specifically professional values or obligations in any profession. There is nothing to which a person is obligated precisely because he or she is a professional.

Some commentators consider the commercial picture to be an accurate description of what professions are like, while others maintain that professionals or the community at large would be better off if professions conformed to this view more thoroughly (Sade, 1971; Kuskey, 1973). But recall that all professional groups have a corner on some valuable form of knowledge within a society. Wherever this is the case, there is power—power to control the knowledge itself and, especially, power over the aspects of human life that depend upon this knowledge. Now compare how various powerful groups are dealt with in our society. Contrast professionals with politicians, for example.

Experience has taught us that politicians will be tempted to misuse their power. Consequently, we want to keep a close eye on them. This is arguably one reason why we accept without too much complaint the terribly inefficient system of periodic reelection, to take one example, because we want to keep close watch over those with political power. It is arguably one reason why we tolerate the excesses of a free press as well, because a free press means that it will be that much harder for politicians to misuse their power.

But the professions, though they do face some slight measure of regulation through licensing boards and the like, are subjected to remarkably little oversight in U.S. society. In fact, even when there is regulation, it is generally their own members who regulate them, not the larger community. The community assures itself that the power of the profession will not be misused by means of the institution of profession.

This suggests that the way in which a profession functions within the larger community is inherently normative. When a person enters a profession, he or she undertakes obligations, obligations whose content has been worked out and is continuously being affirmed or adjusted through an ongoing dialogue between the expert group and the larger community. In other words, there are conventional obligations, over and above obligations incurred in other human relationships, that both individuals and groups have simply because they are members of a profession. Professions and professionals have obligations, and the content of these obligations for each profession is its "professional ethics."

The chief categories of professional norms

Although most professions have articulated a code of ethics or other statements of the norms of their professional practice, such statements are never complete or fully authoritative. They are, at best, good partial representations of the content of the profession's norms and obligations. The full content of these norms is the fruit of an ongoing dialogue between the expert group and the larger community, in whose recognition of experts and grant of professional autonomy the expert group depends for its status as a profession. Therefore, the effort to answer such questions as "What professional norms apply to this situation?" and "What is a member of the profession obligated to do in this situation?" must include asking what the larger community understands those norms and obligations to be, rather than looking only at the views of the professional group or some organization(s) within it.

Determining what a profession's norms are is therefore a much subtler enterprise than it might seem. Even the well-known moral categories of autonomy, beneficence, maleficence, and justice are only a useful starting point. Another way to examine a profession's norms is in terms of eight categories of professional obligation that have been identified from studies of numerous professional groups (Czar and Sokol, 1994). Each of these categories provides a set of questions about the profession's norms, both for personal reflection on one's obligations and for scholarly study and professional ethics education.

Briefly stated, the eight categories of questions about professional obligation are:

1. Who is (are) this profession's chief client(s)?
2. What are the central values of this profession?
3. What is the ideal relationship between a member of this profession and the client?
4. What sacrifices are required of members of this profession and in what respects do the obligations of this profession take priority over other morally relevant considerations affecting its members?
5. What are the norms of competence of this profession?
6. What is the ideal relationship between the member of this profession and coprofessionals?
7. What is the ideal relationship between the member of this profession and the larger community?
8. What are the members of this profession obligated to do to preserve the integrity of their commitment to its values and to educate others about them?

The chief client. Every profession has a chief client or clients. This is the person or set of persons whose well-being the profession and its members are chiefly committed to serving. For some professions, the identification of the chief client seems quite easy. Surely, we might say, the chief client of a physician is a nurse, for example, is the patient. But who is the chief client of a lawyer? Is it simply the party whose case the
lawyer represents or to whom the lawyer gives advice? Lawyers are told and they announce in their self-descriptions and codes of conduct that they have obligations to the whole justice system; therefore, there are things that they as professionals may not ethically do, even if doing them would advance the situation of the party they represent or advise. So it appears that the answer to the question about the chief client of the legal profession is complex, involving not only the persons lawyers represent or advise but the whole justice system and/or perhaps the whole larger community served by that system.

Once this sort of complexity about the chief client is noticed, even those cases that appear to be simple prove more complex. The physician and the nurse must attend not only to the patient before them, for example, but also to those in the waiting room or to the other patients on the hospital unit, and so on. In fact, they have some obligations to all the patients in the institution where they work, or to all their patients of record if they are in private practice. They also have significant obligations to the public as a whole; for example, they are obligated to practice with caution so as not to spread infection from patients they are caring for either to themselves or to other patients.

Who, to take another example, is the chief client of the engineer? Is it the party who will pay the engineer’s fee? Or, if the engineer is employed, is it the engineer’s employer? Or are the engineer’s chief clients possibly the people who will directly use the bridge or the building that the engineer designs, or those whose environment will be affected by whatever the engineer produces?

In any case, this question about the chief client is one of the first questions that must be asked if a particular profession’s obligations are to become clear. It must also, therefore, be one of the first questions we must address when we are educating the members of a profession in their professional obligations.

The central values of the profession. Every profession is focused only on certain aspects of the well-being of its clients. The professions’ rhetoric to the contrary, no professional group is expected by the larger community to be expert in their clients’ whole well-being or to secure for its clients everything that is of value for them. There is, rather, a certain set of values that are the focus of each profession’s expertise and that it is the job and obligation of that profession to work to secure for its clients. These values can be called the profession’s central values.

Most professions are committed to pursuing more than one central value for clients. Whatever other values are central for a given profession, for example, the value of clients’ autonomy is ordinarily a central value as well. Efficiency in the use of resources may have a similar standing. In any case, if there is more than one central value for a given profession, the question can then be asked whether these values are all equal in rank, or whether the members of the profession are committed to choosing them in some ranked order when they cannot all be realized at once.

For example, the values proposed as the central values that the dental profession is committed to pursuing for its patients are, in order of importance, life and general health; oral health, understood as appropriate and pain-free oral functioning; the patient’s autonomy (i.e., the patient’s control), whenever practicable, over what happens to his or her body; preferred patterns of practice on the part of the dentist; aesthetic considerations; and efficiency in the use of resources (Ozar and Sokol, 1994).

For every profession, then, questions need to be asked and answered: What are its central values? What specific aspects of human well-being is it the task of each member of this profession to secure for clients? And if there are more than one, which takes precedence?

The ideal relationship between professional and client. The point of the relationship between a professional and a client is to bring about certain values for the client that cannot be achieved without the expertise of the professional. To achieve this, the professional and the client must both make a number of judgments and choices about the professional’s interventions. This third category of professional norms addresses the proper roles of the professional and the client as they make these judgments and choices.

At least four general models of such relationships can be distinguished: (1) a “commercial model,” in which only the minimal morality of the marketplace governs; in other words, neither party has any obligations beyond a general prohibition of coercion and fraud unless and until individuals freely contract together to be obligated toward each other in specific additional ways; (2) a “guild model,” in which the emphasis is on the professional’s expertise and the client’s lack of it, so that the professional alone is the active member in all judgments and choices about professional services for the client; (3) an “agent model,” in which the expertise of the professional is simply placed at the service of the values and goals of the client without interference by any competing goals or values, including values to which the profession is committed from the start; and (4) an “interactive model,” in which both parties have irreplaceable contributions to make in the decision-making process; the professional offers expertise to help meet the client’s needs and has a commitment to the profession’s central values, and the client brings his or her own values and priorities as well as the value of his or her self-determination. Ideally, in this last model, the two parties choose together how the professional shall benefit the client.

In addition, since the ideal relationship is described in regard to fully functioning adults, a profession’s
norms must also include how its members are to interact with clients who are not capable of full participation in decision making about the profession's interventions; such clients might include children, the developmentally disabled, and persons whose capacity to participate is diminished by fear, illness, or other conditions.

Sacrifice and the relative priority of the client's well-being. Most sociologists who study professions mention "commitment to service" or "commitment to the public" as one of the characteristic features of a profession. Similarly, in most professions' codes of ethics and other self-descriptions, clients' best interest or service to the public is given a prominent place. But these expressions admit of many different interpretations, with significantly different implications for actual practice.

Consider, for example, what could be called a "minimalist" interpretation of this general norm. According to this interpretation, a professional would have an obligation to consider the well-being of the client as only one among the profession's most important concerns. This is called a "minimalist" interpretation because, if any less consideration than this were given, the client's well-being could not be said to have any priority for the professional.

On the other hand, according to a "maximalist" interpretation, the professional has an obligation to place the well-being of clients ahead of every other consideration, both the profession's own interests and all other obligations or concerns that the profession might have.

It is doubtful that either of these interpretations accurately represents what the larger community wants or understands in this matter. Professional obligation almost certainly requires that members of a profession accept certain sacrifices of other interests in the interest of their clients. On the other hand, even if it were only to make certain that the community continued to have a supply of professionals to meet its needs in the future, the larger community certainly does not understand the commitment of the professional person to be absolute or to impose the utmost of sacrifices for the sake of one's client in all circumstances.

Each professional group has, as part of the content of its obligations worked out over time in dialogue with the larger community, an obligation to accept certain kinds of sacrifices, certain degrees of risk in certain matters, and so on. The risk may be of infection, if facing it is necessary for the sake of one's clients, for health professionals; or it may be the risk of financial loss, or the risk of social loss or criticism. In any case, it should certainly be part of reflection on a profession's ethics and part of professional ethics education to raise this issue and to discuss and try to identify the kinds and degrees of risk that are part of that profession's obligations.

Competence. Every professional is obligated both to acquire and to maintain the expertise needed to undertake his or her professional tasks, and every professional is obligated to undertake only those tasks that are within his or her competence.

Competence is probably the most obvious category of professional obligation. It is also the easiest to describe in a general way. For if a professional fails to apply his or her expertise, or fails to obtain the expertise for undertaking some task, these failures directly contradict both the point of being an expert and the very foundation of the larger community's award of decision-making power to the professional in the first place.

But determining what counts as competence on the part of a member of a given profession, both in general and in relation to specific kinds of tasks, is a complex matter. In practice, and almost of necessity, detailed judgments about requisite expertise are left to those who are expert—the profession itself. But the larger community usually requires that explanations be given regarding the general reasoning involved. In particular, it should understand the risk–benefit judgments involved in every determination of minimal competence. For as the level of competence identified as the minimum acceptable in some matter is raised, the relative availability of that level of expertise to the profession's clients will fall.

Ideal relationships between coprofessionals. Each profession also has norms, mostly implicit and unexamined, concerning the proper relationship among members of the same profession in various matters and also among members of different professions when they are dealing with the same client. Some elements of the proper relationship between a family practitioner and a renal specialist, for example, are not matters of etiquette, but bear directly on the medical profession's ability to achieve its proper ends. The same is true of relationships between physicians and nurses, dentists and dental hygienists, dentists and physicians, and so on, when they are caring for the same patient.

Some aspects of these relationships are dictated by each professional's obligation not to practice beyond his or her competence and so to seek assistance from other professionals when a particular matter requires expertise that the first professional does not possess. But other aspects of coprofessional relationships are also governed by professional norms, though they are rarely explicit. For example, how should coprofessionals communicate with a patient about their differing recommendations for the patient when these differences derive, not from differing interpretations of the facts, but from differing philosophies of practice within their profession or from their being members of different professions with different central values?

The relationship between the profession and the larger community. The activities of every
profession also involve diverse relationships between the profession as a group, or its individual members, and persons who are neither core professionals nor clients. These relationships may involve the larger community as a whole, or various significant subgroups, or specific individuals. It is incumbent on a profession that is permitted to be self-regulating by the larger community, for example, that it carry out this task of self-regulation conscientiously. This includes providing and monitoring educational programs and institutions in which new members of the profession receive their formation as professionals. It includes monitoring the collective activities of members of the profession in their various professional organizations to make sure that these organizations act in ways consistent with the other professional obligations of the members. It also includes such measures as are necessary to monitor and correct incompetent or other professionally inappropriate practice on the part of individual members of the group.

The profession as a group and its individual members are also the principal educators of the community regarding such elements of the profession’s expertise as the lay community needs to know to function effectively in ordinary life. Thus, for example, the health professions have obligations regarding public education in matters of ordinary health self-care and hygiene; the engineering and scientific professions have obligations regarding ordinary knowledge of safety practices that the lay community needs to know in daily life.

A more subtle kind of obligation has to do with the content of key value concepts that become part of the public culture and play crucial roles in people’s private lives and especially in public policy, but whose content is significantly influenced by the members of a profession or of a group of professions. For example, the health professions are more responsible than any other group for educating the public about what it means to be healthy; the engineering professions have a powerful formative influence on the culturally dominant notions of safety and physical risk; and so on. This is an area of professional obligation to the larger community that has received little attention, but it seems one of continuing ethical significance.

Integrity and education. Finally, there is that very subtle component of conduct by which a person communicates to others what he or she stands for, not only in the person’s acts themselves but also in how these acts are chosen and in how the person presents himself or herself to others in carrying them out. The two words that seem to communicate the core of this concern are “integrity” and “education,” especially when the two words are paired.

Each profession stands for, or “professes,” certain values that it is committed to bringing about both for its clients individually and for the community at large. But a professional’s personal priorities may communicate a different set of values, even though the professional’s choices of interventions for clients and his or her efforts to secure appropriate relationships with clients all conform to acceptable standards. Concern with this kind of communication to their patients and to the general public, for example, motivates some health professionals to establish in their personal lives patterns of healthy living consonant with what they say to their patients. Failure to accord to this element of professional commitment also makes illegal personal activities on the part of lawyers somehow doubly wrong.

Professionals may be obligated, then, to do some things and to refrain from doing others in order to remain true to the values that their profession stands for and thereby to educate others in these values by their own example.

There are undoubtedly other useful ways of dividing the general topic of professional obligation besides these eight categories. The point is that conceptual tools like the key features of the institution of profession and the principal categories of professional obligation can assist professionals in determining their own obligations in general and in particular cases, and can assist scholars and educators of professional ethics in their work for a clearer understanding of professional practice and of the ethical standards that apply to it.

Alternative views of profession

The account just given explains the institution of profession in terms of its function in society, as a means by which a society secures the benefits of specialized expertise for its members and prevents, or at least limits, its misuse by those who possess it. Like every account of a thing’s function, this account is both descriptive and normative. It describes how professions and their members act, at least for the most part, and it identifies sets of standards by which their successes and failures to act in those ways are to be judged.

The principal alternative ways of explaining the institution of profession can be described under four headings: historical, critical functionalist, radical democratic, and personalist. Each of these approaches separates the descriptive and normative elements that are interwoven in a functionalist account, with the first and second stressing the descriptive elements and the third and fourth the normative elements.

Historical explanations of the institution of profession identify, through historical study, a developmental pattern that brings an occupational group to the point of being considered a profession. This pattern is then used normatively to determine which occupational groups qualify at any given point in time and what patterns of conduct by the group conform or do not conform to the pattern. Some historical studies of professions do not purport to explain the institution of
profession, of course, but simply tell part of its story without attempting to draw normative conclusions. Historical explanations may depend, at least initially, on some functionalist account of profession or on the selection of certain occupations, in their contemporary form or otherwise, as endpoints or at least markers of the developmental process being studied. But once a developmental explanation has been formulated, it can then be offered to replace functionalist accounts on the grounds that these are excessively idealized and are not adequately descriptive of the actual conduct of relevant individuals and groups. For example, the medical profession in the mid-twentieth century has been described as the product of a process of monopolization, or gradual acquisition of control by an exclusive group over a segment of market activity over the years (Berlant, 1975); the institution of profession generally has been described as a specialized mechanism for maintaining economic power and class-based status and dominance (Larson, 1977).

Some critics of the professions formulate a functionalist account of the institution for themselves, or accept someone else’s, and then use its normative content to critique current patterns of conduct of individuals and organizations within a particular profession or across the professions generally (Freidson, 1970b). Other functionalist critics argue that currently accepted functionalist accounts are so idealized—that is, pay so little attention to the gap between what is described as the profession’s function and actual conduct—that they foster harm to the community, or at least complacency for its good. Therefore, an alternative account of the function of professions and professionals is proposed and its implications for professional conduct are identified (Kulten, 1988).

Radical democratic critics of the institution of profession believe that any society that accepts this institution makes a profound mistake. It is central to the institution of profession that the possession of expertise is a basis of power and that one element of that power is a grant of autonomy to those possessed of it. By institutionalizing deep inequalities of power and autonomy in this way, these critics argue, the society makes the achievement of genuine democracy almost impossible. According to the radical democrat, the failures in conduct pointed out by functionalist critics and the developmental patterns leading to monopoly and to other forms of economic and class-based inequality that the historical critics point out are not accidental traits of the institution of profession but the inevitable outcomes of its inherently undemocratic constitution. The solution, on which the well-being of the human community depends, is to do away with this institution, and all other institutions grounded on undemocratic premises (Illich, 1973, 1976). The personalist explanation of profession identifies the individual professional’s act of personal commitment upon entering a profession as the basis of everything morally significant about the institution of profession. As centuries ago a solemn vow initiated a person’s membership into a profession—a vestige of which remains, for example, in the ceremony in which new physicians speak the Hippocratic oath—so today the act of personal commitment by each member of a profession is what brings the profession continually into being and gives it its character. The contents of its norms are determined by the contents of these personal acts of commitment, and the professional who falls short in conduct falls above all to honor his or her own commitment to serve others, rather than failing to follow a norm created and sustained by the mutual effort of the profession, including the individual professional, and the community at large (Pellegrino, 1979; Pellegrino and Thomasma, 1988).

Each of these approaches stresses a feature of the institution of profession that standard functionalist accounts are held to overlook or underestimate: the developmental patterns by which professionals are formed; the extent to which professions’ and professionals’ actual conduct falls short of the functionalist’s proposed norms; the undemocratic character of exclusive expertise; and the centrality of the act of commitment by which a person becomes a professional. More complex functionalist accounts could incorporate much that is stressed in these other approaches, as more complex versions of each of them could incorporate emphases and concerns from the others. From the point of view of understanding professions as we know them, in other words, each of these approaches teaches something of central importance.

Changing times, changing standards, changing concepts

It is not only the conduct of individuals and groups, as measured by professional norms, that can fall short of what it ought to be. Professional norms themselves can fall short of what they ought to be, particularly when important characteristics of the society have changed. There was a time, for example, when the general level of education in the United States may have fostered greater standards of learning by physicians and dentists, and the ideals of the patient—practitioner relationship to be a relationship according to the guild model rather than the interactive model, which has become normative for these professions in the years since the late 1960s.

A profession’s norms and the institution of profession itself are human constructs and, like all things of human making, they can fall short of their intended goals, and the goals in terms of which they are judged can themselves change with changing times. When
and institutions are no longer serviceable to do
tasks that a society needs them to do, then the so-

society is justified in trying to change them. But social

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pare a mode of acting or of organizing conduct that has

been fruitful, and they preserve it by form ing in their

participants strong habits of perceiving, judging, and

acting in ways that support it.

So when times and expectations change, or people's

situations and abilities change, or the surrounding social

institutions change, then it is important to reexamine

the evant norms and institutions to see if they are still

appropriate and to change them if they are not, even if

it involves a major transformation of a particular

profession's norms across many of the eight categories.

One of the weaknesses of functionalist accounts of the

situation of profession in the minds of their critics is

that such accounts seem to say that what is the case is

that ought to be the case. But, like the other four ap-

proaches, the functionalist account is simply a concep-
tual tool whose purpose is to help us understand what

we have when we have a particular profession with a

particular set of norms so we can then make the judg-

ment whether that is the profession we ought to have.

In an analogous way, the new professional enters a

profession whose norms are already in place. This does

not mean that they cannot be changed, but they achieve

their content by means of an ongoing dialogue between

the profession and the larger community, and they

change their content in the same way. So the new

professional cannot create the contents of his or her

professional obligations out of whole cloth. Yet, even in

the individual case, the norms of the profession are not

the ultimate determiners of right and wrong; if these

norms are in conflict with one another or with other

important moral considerations, or if they are severely

defective in some way, then the professional must form

his or her conscience carefully in choosing how to act.

Situations will arise in which conscientious disobedi-

cence of a professional norm will be what a person's moral

judgment requires when all things about a situation are

considered.

By what standards should a society judge a profess-

i on's norms when their adequacy to the society's needs

is in question? By what standard should the institution

of profession itself be judged? By what standard should

the individual professional form his or her conscience

when conflict or severe doubt about the adequacy of a

professional norm in a particular case suggests that con-

scientious disobedience may be the correct path? Surely

not by the norms of the profession, for these are pre-

cisely what are being challenged when such questions

arise. It is to the deeper values and standards of human

conduct and social life that we must turn at such times,

for it is upon them that the norms or professions rest for

their moral force in the first place.

As is true for many other human institutions, if we

do not have the institution of profession, we would need

to invent it or something like it in order to live together

effectively. For we live in a world where no one person

can master all the knowledge and skills on which the

achievement of so many important values in human life

depend. But, like other human institutions, the institu-

tion of profession as a whole, and each individual

profession, and each normative feature of each profes-

sion, requires regular ethical scrutiny to make sure it

continues to fulfill the purposes for which it was made.

One of the principal roles of the field of bioethics and

its practitioners is to provide the members of the health

professions and the larger community with effective con-

ceptual tools to employ in this scrutiny.

DAVID T. CZAR

Directly related to this entry are the entries MEDICINE

AS A PROFESSION; NURSING AS A PROFESSION; ALLIED

HEALTH PROFESSIONS; TEAMS, HEALTH-CARE; PROFESSION-

AL-PATIENT RELATIONSHIP, articles on HISTORICAL

PERSPECTIVES, SOCIOLOGICAL PERSPECTIVES, AND ETHI-

CAL ISSUES; HEALTH OFFICIALS AND THEIR RESPONSIBIL-

ITIES; AND LICENSING, DISCIPLINE, AND REGULATION

IN THE HEALTH PROFESSIONS. This entry will find appli-
cation in the entries DIVIDED LOYALTIES IN MENTAL,

HEALTH CARE; IMPAIRED PROFESSIONALS; PSYCHIATRY,

ABUSES OF; AND SEXUAL ETHICS AND PROFESSIONAL

STANDARDS. For a discussion of related ideas, see the

entries AUTONOMY; COMPETENCE; CONFIDENTIALITY;

INFORMATION DISCLOSURE; INFORMED CONSENT; AND

RESPONSIBILITY. For a discussion of the development of

medical ethics within medical professions, see the extend-

ive entry MEDICAL ETHICS, HISTORY OF. Other relevant

material may be found under the entries BIOETHICS EDU-

CATION; GENETIC COUNSELING, article on PRACTICE

OF GENETIC COUNSELING; and MEDICAL CODES AND

OATHS. See also the Appendix (Codes, Oaths, and

DIRECTIVES RELATED TO BIOETHICS), SECTION II: ETHI-

CAL DIRECTIVES FOR THE PRACTICE OF MEDICINE; SEC-

TION III: ETHICAL DIRECTIVES FOR OTHER HEALTH-CARE

PROFESSIONS; and SECTION IV: ETHICAL DIRECTIVES FOR

HUMAN RESEARCH.

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