The Meanings of Professional Life: Teaching Across the Health Professions

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ABSTRACT

Most of professional ethics is grounded on the assumption that we can speak meaningfully about particular, insulated professions with aims and goals, that conceptually there exists a clear “inside and outside” to any given profession. Professional ethics has also inherited the two-part assumption from mainstream moral philosophy that we can speak meaningfully about agent-relative versus agent-neutral moral perspectives, and further, that it is only from the agent-neutral perspective that we can truly evaluate our professional moral aims, rules, and practices. Several important changes that have occurred, or are currently taking place, in the structure of the health care professions, challenge those assumptions and signal the need for teachers of professional ethics to rethink the content of what we teach as well as our teaching methods. The changes include: influences and critique from other professions and from those who are served by the health professions, and influences and critique from professionals themselves, including increased activism and dissent from within the professions. The discussion focuses on changes that have occurred in the health-related fields, but insofar as similar changes are occurring in other professions such as law and business, these arguments will have broader conceptual implications for the way we ought to think about professional ethics more generally.

Keywords: dissent, meaning, narrative, positivism, professional ethics, teaching

How should we evaluate the actions of professionals? Are lawyers liars? Are tax collectors crooks? Are foreign aid workers saints? Or are they just doing their jobs? What lends moral content to the ethical rules of a profession? These questions are as old as the professions, but they are not by any means settled. The fact that philosophers continue to puzzle over the sources of professional normativity reflects also a more general sense of uncertainty about the moral aspects of professional life. Our working world is no longer the one of F.H. Bradley’s “My Station and Its Duties,” or the myopically...
dutiful Butler Stevens in *The Remains of the Day*. Being a professional in our time has become more complicated. Contemporary professional roles are more transparent and open to critique, and open to influences from other roles and professions. The sources of professional normativity are varied, including more than ever the personal moral views of professionals. Yet most of us who think about and teach professional ethics have not let go of our assumptions regarding certain moral features of professional ethics. I think especially those of us trained in philosophy tend to think in terms of “inside and outside” the profession, when we evaluate the behavior of professionals or the goals and aims of particular professions, like medicine or law. A philosopher writing on this very issue wrote: “If I am a firefighter, I may have a role-obligation to enter a burning building” (Hardimon, p. 335). I was recently watching the news and a reporter said, “As a brave person and proud son he chose to be a firefighter, like his father, and without thinking he climbed those stairs to his certain death to save countless innocent lives.” The real life problems of professional duty, professional pride, and professional shame are of course more complicated than our theories of applied ethics reflect. If our theories were exactly as inelegant and complicated as the real world, it would probably be difficult to make headway, to gain clarity and perspective, to identify basic concepts and to evaluate and offer criticism. There are, however, two assumptions that most of us still make about the structure of the professions, that seem seriously false: (1) Most of professional ethics is grounded on the assumption that we can speak meaningfully about particular, insulated professions, that conceptually there exists a clear “inside and outside” to any given profession. The thought is, if we can simply identify the dominant goal or purpose of firefighting, we can derive the obligation to enter burning buildings. The obligation remains, importantly, one justified from within the profession. We can evaluate and criticize the obligation to enter burning buildings in terms of how well or poorly it reflects the profession’s aims, or we can step outside the role of firefighter and see how well the purpose or aim fares when mapped against more general moral principles, like the duty to rescue those who are in distress. (2) Professional ethics has also inherited the two-part assumption from mainstream moral philosophy that we can speak meaningfully about agent-relative versus agent-neutral moral perspectives, and further, that it is only from the agent-neutral perspective that we can truly evaluate our professional moral aims, rules, and practices.

I think we should reject these two underlying assumptions on the grounds that they fail to reflect the lives of real professionals in morally significant
ways. To defend this view I will focus on several important changes that have occurred, or are currently taking place, in the structure of the health care professions. Since those of us who are trained in professional ethics typically teach and offer substantive moral guidance to professionals, this issue of what gives moral content to the morality of a profession becomes more than a mere theoretical exercise – if correct, then perhaps we should rethink the content of what we teach as well as our teaching methods. I would like to suggest that the image of the professional putting on and taking off the special duties of his profession, as a pilot puts on and takes off his flight uniform, is not an accurate picture of professional life. Since I work primarily with health professionals, I will focus on changes that have occurred in the health-related fields, but insofar as similar changes are occurring in other professions such as law and business, these arguments will have broader implications for the way we ought to think about professional ethics more generally.

I. INFLUENCE, CRITICISM, AND THE TRANSPARENCY OF THE HEALTH PROFESSIONS

When we ask what gives content to the specific moral duties of a profession or role, we most often appeal to the purpose, aim, or function of the profession as a way of filling out the details. On the “practice-positivist” model, for example, which holds that the content of professional moral codes is internal to the profession, a moral rule like “First do no harm” finds its normative force in the purpose of the medical enterprise – to heal, to mend, to cure, to alleviate suffering. Positivist accounts of medicine make more exclusive reference to the aims or purpose of a profession, since there is no communication between universal moral rules and the internal workings of a practice. The internally defined rules of the game will make reference to what the majority agree to as being the purposes or functions of the profession (Veatch, 1983). Arthur Applbaum has put forward the most recent and most elegant version of this model, which is analogous to arguments made by legal positivists, regarding the relationship between morality and the law of specific societies (Applbaum, 1999, pp. 58-59). For the legal positivist moral law, or natural law, does not directly inform or constrain the moral content of the laws in particular societies. Similarly for the practice positivist, professional moral rules are products of particular professional convention, not reason, and not universal moral principles. Dissent and moral criticism must necessarily come
from outside the professional role. The question of obligation, as well, is not a role-relative question, but rather stems from person-neutral prescriptions of fair play, including agreement to play by the rules, or the acceptance of the benefits and burdens of the professional role (Applbaum, 1999, p. 59). Within the context of the legal profession, lies of omission under the attorney-client privilege are simply rules with a function – they serve the professional aim of offering clients a fair and unbiased defense in the game that is law. To ask, “Are Lawyers Liars?” is to necessarily take up a position outside the positive description of a profession and to invoke external, not internal, criteria of moral evaluation.

A long-recognized difficulty with this approach is that it assumes agreement about the purposes or ends of particular professions, and there is some disagreement about the purpose, especially the dominant purpose, of a field as diverse as medicine (Engelhardt, 1996; May, 1983, pp. 101-102). Historically, the aims of medicine have included: curing and preventing illness, ensuring the health and well-being of patients, minimizing suffering and loss, extending compassion and care to those who are suffering, and advancing the aims of scientific knowledge and discovery. The moral obligations of a physician toward a depressed cancer patient who requests that life-support be discontinued will vary, depending on the aim we choose to emphasize. To add to the longstanding internal disagreement about the proper ends of medicine, we must also consider the affects on the goals of medicine from outside the profession, in particular, from nursing, payers, and health care organizations.

The new models for health care delivery vying for ascendancy are all variations on a structure that overtly blends medicine and business. There has been much discussion of the ways in which the move to managed care exacerbates longstanding ethical problems and creates new conflicts of interest (American Medical Association, 1995). Physicians now wear many hats, playing (often simultaneously) the role of care-giver, counselor, administrator, patient advocate, teacher, researcher, accountant, and auditor. The aims of business – including efficiency, profit, stability, customer satisfaction – have influenced the aims of the health professions in a variety of ways. Managed care structures and the aims of efficiency have encouraged a clinical division of labor that often splinters the continuity of care. In some cases, this change has impacted the sense of personal responsibility that particular health care workers feel for particular patients. For example, in the course of launching a task force on palliative care in one of our affiliated hospitals, one of the obstacles we encountered in the managed care groups in the facility was a
refusal of any one doctor to take responsibility for end-of-life care. It seemed that no one wanted to accept the difficult task of discussing pain management, hospice, financial affairs, and burial arrangements with the patient. With as many as 4 or 5 specialists involved in the care of a terminal patient, each with very targeted and narrow objectives, it was relatively easy for individual clinicians to pass the buck on palliative care (with the buck stopping, too often, with hospice, and often with only 48 hours left in the patient’s life). As one cardiologist in the group said, “I do hearts, not living wills.” Increasingly, specialists must wrestle with the dreaded image of the “body-mechanic” – the perception (and self-perception) that they are mere technicians, removed from the broader “profession of medicine” as a discipline, art, and practice. The good news is that the long and rich tradition of hospice care is beginning to influence the standard practice of medicine. The goal of securing, above all, a dignified and meaningful death for one’s patient had been the goal of a separate speciality within medicine and nursing. With the educational efforts and activism of those who have long worked within this tradition, we are finally seeing a significant move in mainstream medicine toward the adoption of this goal.

The aims of the nursing profession also continue to impact the goals of medicine. Nurses are challenging physicians to rethink the physician–patient relationship in more relationship–centered terms. In ethical conflict nursing has long drawn our attention to the relations outside the physician–patient relationship, including family dynamics, relationship with clergy, and relationships between health professionals involved in the patient’s care. This is a perspective on patient care and interprofessional relationships that goes to the heart of the nursing profession, but it is an idea that still seems novel to many physicians (Laine & Davidoff, 1996; Pew-Fetzer, 1994).

The aims of social work have also been recently influential on nursing and the medical professions. Historically, the profession has always placed emphasis on the value and goal of justice and empowerment, as we see in the preamble of the National Association of Social Workers Code of Ethics: “The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty” (NASW, 1999, p. 1). In a recent consultation involving a sixty-seven year old woman, unresponsive, with multiple systems failure, on an ICU, the physician expressed frustration at the daughter’s unwillingness to move to hospice care for her mother, who was clearly not benefitting from the
type of aggressive care being offered on the unit. The nurses, physicians, and members of the ethics committee who were involved in the case agreed that this was a case of inappropriate care, that a move to palliative care was both clinically and ethically justified. The daughter would agree to a do-not-resuscitate-order, then rescind it. She would reluctantly agree to a hospice transfer, then change her mind. It was not until a social worker shared one of the daughter’s comments that the grounds for her reluctance became clear. She had said to the social worker, “Don’t I deserve this much for my mother? Is this really too much to ask? All my friends tell me that if I send my Mom off to Hospice, I’m sending her off to die. I don’t want to put her down like an animal.” The daughter and patient were African American and after talking to her further, it became clear that the daughter saw this decision as a racially charged one. If her mother were white, she would not be pushed off to hospice. There was also the history of blacks in Houston to be considered. She was old enough to be part of a generation of African Americans denied access to the best hospitals in Houston, and now that she enjoys equal access along with whites, she is being told that her mother cannot partake in the best technology available, that this technology would have to be withdrawn, taken away. This is how the daughter saw the situation, in part, and without this shift in thinking prompted by the social worker, I suspect that none of us would have appreciated the daughter’s moral perspective. The clinical reasons for thinking this a case of medical futility remained, but we had additional reasons for communicating and compromising with the daughter in a way that addressed some of her very deep moral concerns. After further discussions with the social worker on the case and after meeting with a nurse from the local hospice, the daughter agreed to have her mother transferred to a hospice unit and seemed to feel more comfortable with the decision. Social work as a profession has long been in the business of providing what Hilde Nelson has referred to as counter-narrative, challenging the going moral assumptions and consensus by invoking powerful stories of the unrepresented or subjugated points of view (Nelson, 1995). The social worker on this case did exactly that.

This kind of cross-professional influence has been greatly facilitated by the move toward team-based decision-making. These interprofessional discussions encourage a healthy cross-pollination among the different moral perspectives of the professionals, sometimes resulting in disagreement, but also resulting in a new appreciation for the moral assumptions of particular practices. We are seeing a similar form of interprofessional influence in multinational research teams, as reflected in the growing body of international
guidelines on research ethics (Brody, 1998). By opening up the borders of our practices and professions we usher in counter-influences and critique.

The walls of the health professions are also becoming more transparent to people who were formerly treated as “outsiders” – namely, the patients. Again, this has opened up the professions to evaluation, criticism, and influence from the “consumers” whom the professions serve. Changes in information technology and the rise of the internet have radically changed the role of the patient. Patients have easy access to medical knowledge and information, including information about their own treatment and history as contained in the formerly protected medical record. Patients in Europe and the United States and in developed areas of Asia and South America, now play a much more involved, aggressive, and informed role in their care than they did even ten years ago. The internet and other information technologies have helped erode medicine’s monopoly on information about health, disease, treatments and cures. Patients, formerly outsiders, are now insiders, arriving at their appointments with armfuls of printouts from web pages, and photocopies of their medical records.

These changes, taken together, suggest a need to revise our assumptions about the normative structure of individual professions and a need to discard the “inside-outside” distinction, where particular professions are concerned, and where professions and consumers are concerned. Because of the variety of personal understandings of professional purpose and the cross-pollination between the health professions it now makes less sense to try to identify or articulate a single purpose for any particular health profession, or even a dominant purpose. Rather, the way we come to truly rely on the varied understandings of professional purpose will be through the process of joint-moral deliberation, conversation, and open critique.

II. THE PERSONAL VOICE OF THE HEALTH PROFESSIONAL

Another standard challenge to the idea that we should derive particular professional duties from the aims of insulated professions is that not only are professions divided on the purposes of the practice, but professionals are divided in the way they interpret the aims of the profession as set out by professional leaders and the writers of codes (Sher, 1996, p. 481). This long-standing difficulty is being exacerbated by another change that is taking place within the culture of the health professions. Health care professionals are
increasingly voicing personal concerns and personal moral commitments, challenging the assumption in favor of “professionalism” or agent-neutrality. Hospitals, as institutions, are recognizing various needs of professionals: the need to share their own concerns, the need to grieve, the need for relief of stress, and the need to voice their own moral values as persons and not merely as professionals. In the literature on palliative care and death and dying, for example, there is increased discussion of how institutions can better support the hospital staff’s personal needs surrounding the death of patients. This has long been a central concern for those working in hospice care, but now we are beginning to see the personal turn in other areas of health care. We see professionals trying to own rather than inherit their sense of professional purpose.

Alasdair McIntyre has described the moral life as one in which each person is living in a role, seeking a unified narrative for a life (MacIntyre, 1981, p. 201). It is doubtful that human beings seek such a unified account, at least insofar as they are moving ahead and not looking back on a life with revisionist and unifying intent. But even if not a unified vision, why is it that we have set the professional aspect of our moral lives apart from our more personal moral commitments and goals? The bias in professional ethics has been toward neutrality, suppressing one’s personal moral beliefs in the workplace. If professional life is largely inseparable from moral life, requirements to take the agent-neutral perspective in our evaluations of moral choices and actions can do violence to the moral commitments and moral personality of individual professionals. The standard models of the relationship between morality and the ethical codes of professions have largely failed to include an account of the internal experience of the professional.

A profession is generally defined as an organized grouping of individuals and practices for the sake of providing a service, or services, with criteria and standards for competency, often including licensing requirements. Health care professionals provide health services and as such share in common the client-oriented nature of other service industries. Is that all? One of the implications of (or perhaps the impetus for) the move away from person-neutrality in the professions is the basic human desire for meaningful work, a luxury of modern times and development. Being a member of a profession can be a tremendous source of meaning, satisfaction, and pride. In this sense, a profession can serve the professional. Of course, not everyone is fortunate enough to choose their profession with great reflection. Often, people follow their skills wherever they may lead and may or may not choose to develop those skills that they find particularly rewarding and meaningful. But even for those who find them-
selves in a job without much deliberate choice, the professional life is such a
significant part of one’s daily activities that it cannot help but become a
significant space for expressing one’s values. The result is that more and more
professionals are contributing their own vision of what the purpose of their
role ought to be.

To give an example, I like to ask the pediatric residents, when they begin
their ethics rotation, why they chose pediatrics. In four years of teaching these
rotations, I’ve yet to get the same answer. And the most moving answer was
from a resident who said she thought pediatricians were in a unique position to
help children who have no one else to look to for support and security. What
she meant by this became clearer when we discussed the appropriate use of
CPS (Child Protective Services) in ambiguous cases of mild nutritional
neglect, but not overt abuse. In this common clash between preventing harm
and respecting the sanctity of a family and parental autonomy she placed
much greater weight on the well-being of the child in her deliberations than
the rest of us in the group. She supported this with an argument based on the
defenselessness of children and an appeal to their basic needs. When pressed
by one of her colleagues she responded with candid emotion, and said, “Look,
I was abused as a child and I know what it’s like not to have anyone rescue me,
not to have anyone to turn to. That’s why I went into pediatrics, to help these
children.” I’ve conveyed this story to several people and so far I’ve had two
people (a bioethicist and a pediatrician) say that this woman should not be in
pediatrics because she obviously does not have the level of detachment needed
to perform her job responsibly. Insofar as this resident is simply more
heightened to the painful experiences of children, assuming she acts with due
consideration toward parents and others involved in the child’s well-being, is
she not to be admired? Is she not a much needed source of moral inspiration?
She strikes me as someone who has chosen to take up the moral space in her
profession that is left undetermined by moral principles and statements passed
down by the American Medical Association (AMA) and The American
Academy of Pediatrics, and to put her personal stamp on it, to define it in a
way that makes her professional life a meaningful and purposeful one. Her
colleagues around the table during our session were visibly moved by the force
of her moral perspective; I could see them struggling to revise their moral
arguments to better capture the asymmetry between the suffering of an abused
child and an independent adult, capable of self-defense. What she said and the
way she said it was extremely moving, in a substantive moral sense. She
moved us to change our views about the moral aims of being a pediatrician.
What we begin to see in this case is the double-edged nature of the personal element in moral decision-making. Accounts like this, and attempts to incorporate the personal moral commitments of individual professionals into professional ethics, raise the difficult question about the appropriate place for dissent and activism within a profession. The pediatric resident was both moral champion and moral dissenter, potentially offering inspiration or disruption, or both. How should we manage professional dissenters?

Concerns about the instability caused by dissenters go back at least to Hobbes’ Foole and Hume’s Knave, and arguably to Plato’s Glaucon. Arthur Applbaum, in his recent and rigorous defense of a positivist account of professional morality, follows Hobbes and John Austin in placing the professional moral dissenter logically outside the rules of the game. In fact on his view it may be a mistake to call such rebels professionals at all. He does allow for critical roles within the profession, and within the positivist logic, as long as the profession specifies in its rules a place for appeal and dissent. In the health care professions, the model of the Institutional Review Board, organizational ethics committee, or hospital-wide task forces on new problems and issues can be seen as just this sort of safe avenue for gradual change and criticism within the professions. Although I have to say, having served on a fair share of such committees and task forces, I am a little skeptical of achieving moral inspiration by committee. I have encountered a few people whom I would call moral activists, and they are typically those people who are so busy being activists that they don’t have time to come to meetings. So, while the classic approach to handling the destabilizing presence of a dissenter is to carve out an explicit place for them, sometimes the roles we set aside for such individuals discourage truly critical participation by being deeply institutionalized roles.

One of the costs of shifting to the management model of medicine, as opposed to a more entrepreneurial or practice model, is that it diminishes the space for what Richard Posner has called “moral entrepreneurs,” those who act as agents of change and inspiration (or agents of reinforcement of values they feel are being wrongly eclipsed) (Posner, 1998). Posner calls for a much needed return to Aristotle’s vision of the moral exemplar, though perhaps with a more Homeric twist, reflecting the real depth of human striving and hubris, with all its frailty, fallibility, and hope. Moral entrepreneurs, by definition, question the rules of the game and seek out new ways of understanding the moral life. With the move to a management model, however, we see a diffusion of moral responsibility and a dampening effect on any given
individual’s ability to make an example. Time pressures, more than ever, make it difficult for social workers, nurses, and physicians alike to champion a cause or to serve as diligent patient advocates.

In the health care professions, as with any profession, there is a nexus of agreed-upon expectations, moral conventions, and standards of practice, some stemming from more widely accepted moral principles, some stemming from the multiple aims of the profession, still others from the purpose as interpreted and created by individual practitioners. We should try to reopen this space for two reasons: First, insofar as leading a good life involves some level of moral engagement, the art of leading a good professional life and developing as a moral person within a professional role should call for a person to express her ideas about what it means to be a good doctor, a good nurse, or a great teacher. Second, part of what it is to work through the deep mysteries of morality as persons, organizations, and societies, is to leave space for the moral entrepreneurs, those who may challenge the dominant view of a profession’s purpose and not shy away from taking a substantive stand on the difficult moral questions faced by particular professionals. The views of the moral entrepreneurs often serve as important signals indicating a need for deeper moral reflection and change.

Given the crucial normative role that these internal critics play in the revision of moral content in professional and moral life, how should we accommodate them? One approach is to endorse procedural mechanisms that make room for reasonable critique. Take for example the AMA’s guidelines on fetal tissue transplantation (AMA, 2000, 2.161). The code offers specific practical steps for separating the decision to have an abortion from the decision to conduct research on the tissue. But what the steps do, in effect, is the equivalent of sending two enraged boxers to their respective corners, only to release them again at the bell. Researchers, tissue donors, and those writing policies on this issue are not helped by this call for separation of the offending moral beliefs. A researcher who believes abortion is wrong must still decide whether or not, by conducting fetal research, she is in some way morally complicit in the prior abortion. Her set of moral beliefs, her understanding of the aims and purposes of scientific research, her more personal reasons for conducting, say, Parkinson’s research, perhaps her identity as a Roman Catholic, the influence of her research colleagues – all of these will shape the moral content of her judgment about whether or not to participate in the research.

What we have in this case is a pragmatic strategy, a way of avoiding the more difficult moral questions about the use of aborted fetal tissue. The
individual researcher and the individual donor must still make moral judgments about the rightness or wrongness of abortion, complicity with an act they may find morally wrong, or the moral legitimacy of overcoming a past wrong with future benefits (in this case, the benefits of research). They are more likely to find greater guidance from their own system of moral beliefs and from the advice of a moral confidant or a discussion among colleagues, than they are from the major professional code of medicine. Just as general moral prohibitions like “Do not harm others” are underdetermined on the question “What should I do?” in specific cases, so too do many professional guidelines underdetermine ethical conduct. As teachers and guides to action, appeals to ethical codes of professional conduct, alone, will be unhelpful. Moral motivators will need to be more resourceful, appealing to example, reasoning by analogy, appealing to pragmatic as well as moral reasons. Such cases reveal the degree to which substantive moral content enters into professional moral decision-making at the level of discrete moral judgments.

III. TEAM-BASED DECISION-MAKING

Groups of professionals have long been defining the specific content of professional moral rules, applying theory to practice, and arriving at standards of care and protocols for good practice. This sort of team-based moral reasoning has not changed; if anything, it is on the rise (Baker, Latham, & Emanuel, 1999). What has changed is that moral deliberation about discrete cases, about specific patients, is including a broader array of deliberators, and individual deliberators are realizing the importance of expressing their own moral commitments. Admitting competing moral perspectives within the process of deliberation can lead to multiple reflective equilibria in the understandings of the relationship between moral rules and the features of the case. The team-approach challenges the standard picture of the clear-cut physician–patient fiduciary relationship. The patient’s trust is placed in more than one pair of hands, and the question of obligation and responsibility becomes more complicated as it is diffused across agents. Where this shift in the structure of moral deliberation has occurred, where decisions are truly team-based, it may be inappropriate to seek a singular reflective equilibrium as the goal of deliberation. To do so would not adequately capture the moral features of fiduciary responsibility in the team setting, and would be to dissolve the importantly distinct equilibria reached in our more complex
cases. It may be that teams of diverse individuals deliberating over tough cases will arrive at a consensus and, on reflection, may arrive at a reflective equilibrium, but that ought to be an accidental by-product, not the end goal in those situations where the truth is in the details and idiosyncrasies of the case and persons involved in it.

In an important way this level of incompleteness or lack of certainty can actually be of practical advantage in the clinical setting. In complex moral choices, arriving at several equilibria offers several ethically justified alternatives. If the first alternative fails, once implemented, the team does not have to restart deliberation from scratch; they can turn to the next best alternative (or what was thought the equally best alternative). This can give a team a powerful preventive ethics advantage when faced with family or surrogate refusals. Instead of dissolving into disagreement, they can turn to the back-up plan of care. The equilibria model asks us to expect difference in our moral perceptions and be prepared for it, rather than paralyzed by it.

The move toward team-based decision-making is due to a complex mix of social, professional, and economic forces, but it can be philosophically motivated by an appeal to the necessary incompleteness of individual moral judgments in settings like the large, urban hospital where the lines of promise, obligation, and trust can often be traced to several healthcare professionals and where the knowledge of particular patients is divided among them. The professionals involved in a case are so often like the eye-witnesses of an auto accident, each providing pieces of the event, some contradictory, some exaggerated, some frank and unblinking. Arriving at a more complete understanding of a patient’s goals and values in this setting depends upon the exchange of information and perceptions among professionals and across professions, with each professional contributing moral data to the decision.

One of the serious difficulties that this move raises is a familiar problem in political philosophy. If the phenomenon of moral discourse is one where the locus of judgment is a mix of individual and group judgments, each bringing different moral data to the table, not to mention diverse moral perceptions of the same event, then the idea that we might somehow transcend such plurality and subjectivity to arrive at a single, even final, public judgment about discrete moral problems seems a theoretical artifice at best. This seems to suggest that it would be a mistake to rely on something like the concept of “public reason” as a filter for justifying the moral practices of particular professions, and that perhaps alternative conceptions of justification would be more suited to the structure of professional life.
IV. TEACHING ACROSS THE HEALTH PROFESSIONS

In the health care professions, the economic pressures to fill many roles, the move toward more collaborative decision-making, the increased openness to internal and external critique, and the lowering of the person-neutral guard, call for some changes in the way bioethicists teach health professionals.

If professional moral purposes and aims are becoming significantly interdisciplinary, then perhaps we should be doing more to incorporate discussion of these cross-professional influences in our classroom and clinical teaching. This would involve offering interdisciplinary learning opportunities, with more interdisciplinary students, rather than placing emphasis on profession-specific courses, such as medical ethics, ethics and cell biology, nursing ethics, social work ethics, and so forth.

One approach, and something that bioethics programs have been doing for some time, calls for collaborative teaching. Michael Davis has asked the almost embarrassing question, “Why should philosophers be teaching the ethics of someone else’s profession?” (Davis, 1990, pp. 21-22). One answer is to admit that philosophers are not always the most effective teachers of ethics in the trenches. Sometimes we should be training the trainers. For example, in our affiliated hospitals there is a terrific and dynamic department of nursing education, including a registered nurse with 25 years of experience in obstetrics and a doctorate degree in bioethics. In this case we have found it more effective to train nurse educators on ethical issues and decision-making and to work with them on developing the materials for teaching nurses on the units. The nurse educators are also unit nurses or managers and have a much more intimate and nuanced appreciation for the moral problems the nurses face on the different units. We have also relied on needs-assessment discussions with senior social workers, nurse managers, and physicians from various services to get a better sense for the educational priorities of the different areas and services. Our hospital education program is based in important part on the ideas and issues raised in these focus-groups, as are the interdisciplinary panel discussions at Ethics Grand Rounds. Through these discussions we get a real sense of what particular professionals in a particular hospital see as the central ethical aims and concerns of their area or practice. While some of the teaching content comes from the ethical codes of these professions, it is only through these kinds of conversations that we arrive at a better understanding of the profession’s more specific moral content. Philosophers are then well-suited to offer health care professionals the tools to push for consistency and coherence,
to question and probe the justifications for their views, to offer reasons to those who disagree, to recognize the moral facts or features of a situation, as well as conflicts between those facts, to offer arguments for a particular resolution of a moral conflict, and to reflect on their decision after-the-fact, thinking about how they might handle future situations, building a store of moral and practical wisdom.

Because the changes I have mentioned also give us reason to rethink the nature of moral judgment in professional settings, we should encourage efforts to deliberate among other professionals, not simply other physicians, in a medical ethics course, or other nurses in a nursing ethics course. Teaching against the backdrop of value pluralism, the one constant we hope to pass on to our students, trainees, and professional colleagues is the ability to make reliable moral judgments about divergent and often conflicting values in less than ideal circumstances. If we could identify a single unvaried procedure for sound moral judgments, our jobs as teachers of ethics in the professions might go the way of the typewriter repairman; we wouldn’t be needed. Increasingly health care professionals are being encouraged to combine moral data, combine narrative, cross professional boundaries, and incorporate the moral perspectives of others. It is hard to imagine a single account of reason-based judgment that embraces that level of moral and cognitive variation. These changes also give us reason to rethink how we handle the always-difficult question of dissent and activism.

V. CONCLUSION

The walls of the health professions are becoming more transparent to people who were formerly considered “outsiders” – other professionals and those whom the professions serve. Economic and organizational pressures are encouraging multi-tasking and collaboration, and these forces are at the same time affecting the nature of professional moral decision-making. Although health care professionals remain bound to patients by certain fiduciary obligations, the moral content of those specific obligations is now subject to different interpretations, open to substantive influences from other professionals, and subject to the professional’s personal understanding of, and stake in the profession. These specific obligations are also frequently undertaken by several professionals at once, and often the product of team-based discussions and deliberation. I have highlighted these changes that are taking place in the
health professions, to challenge the assumptions we make about the moral structure of the professions and about the inner experience of professionals. These claims, taken together, give us reason to rethink some of our long-standing assumptions about the normative insularity of professions and the plausibility of the agent-relative/agent-neutral distinction as it applies to professional ethics. These changes also reflect in an interesting way on the professional roles of bioethicists, many of whom are also physicians, nurses, lawyers, sociologists, literary critics, and philosophers. The aims of our relatively young field already reflect deep diversity, disagreement, activism, collaboration, and the personal voices of those who have taken up the profession.

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