Is Bioethics A Profession?

Is Health Ethics A Profession?

Craig M. Klugman, Ph.D.
Associate Professor of Bioethics and Medical Humanities, Chair of Health Ethics Program
University of Nevada Reno

Abstract
Is Health Ethics a Profession ?

The development of an occupation into a profession is an historical process that concerns power, jurisdiction, social contracts, and economic interests. Sociological theories of professionalization view these developments through perspectives of superior work, pay for performance, historical processes, jurisdictional disputes, struggles of social and economic power, and virtues. This essay explores these theories and examines the field of bioethics through each of these lenses looking at such issues amateur versus professional, education, professional organizations, specialized knowledge, code of ethics, jurisdiction, work sites, work focus, research, socialization, professional autonomy, licensure, legislation, and prestige. Bioethics is seen as falling in the middle of Goode's "profession continuum." While bioethics has adopted some of the necessary characteristics of a profession, having those elements is not a sufficient condition to being a profession. In the end, professionalization is undesirable for the field.
Key Words: ***bioethics, professionalism, profession, education, organizations***

Is Health Ethics a Profession ?
Craig M. Klugman, PhD

A student pursuing simultaneous graduate degrees in health ethics and medical anthropology attends a mentoring breakfast with a respected, senior member of the health ethics community at the annual meeting of the American Society for Bioethics & Humanities. The esteemed senior member says to the graduate student, "You seem really intelligent. It's too bad you'll never work in health ethics because you don't have a philosophy degree."

A junior faculty member with "bioethics" in his title interviews for a clinical ethicist position at a prestigious academic medical center. After the fourth round of interviews, the search chair, an M.D., tells the job applicant that he has all the skills and experiences for which they are searching. "It's too bad you'll never get a job in clinical ethics because you don't have an M.D." [i]

Both of the above true scenarios ask the question of what it means to be a professional health ethicist.[ii] *Must* health ethicists come from certain disciplines? Is a specific degree required? And how do health ethicists fit into the work site, which is commonly an academic health science center, a hospital, or a government agency? The issue of professionalization is an important one as it gives practitioners social standing as well as social control over particular areas of knowledge, training, practice, and entry into the field.

In his 2004 American Society for Bioethics & Humanities (ASBH) Presidential Address, Art Derse briefly asked whether health ethics was a profession (Derse, 2005). The question is an important one as health ethics moves into the future. Even if health ethicists understand how they all relate and work together (Kopelman, 1998), those outside of the field may have trouble understanding this relationship. Criticisms such as Ruth Shalit's "When We Were Philosopher Kings" and Wesley Smith's Culture of Death suggest that many people are suspect of the entire bioethical enterprise and those who claim to practice it (Shalit, 1997; Smith, 2001).

What is a profession?

The sociological literature on professionalism offers many different and varied criteria for differentiating a profession from a non-profession (Bayles, 1981; Freidson, 1994). What makes the three traditional professions of medicine, law, and clergy unique from other jobs? The result is a spectrum of definitions that range from descriptive (excellence; receiving payment; lists of virtues and traits) to process-oriented (historical trends, jurisdictional monopolization, and battles for social and economic power). The remainder of this essay examines these various criteria and processes in relation to health ethics.

Excellence (descriptive)

William O'Donnell suggests this standard of superior work in his examination of social insurance as a profession (O'Donnell, 1967). This benchmark would suggest that the level of passion a practitioner has for his craft and the standard of work required needs to meet a higher bar. Using *professional* in this manner would be saying that someone has done a "professional job" in his or her work. This first notion of professional does not offer much in the way of differentiating between professional and nonprofessional occupations.

Payment (descriptive)

The second way that the term professional is used is simply in performance for pay. A *professional* is distinguished from an *amateur* by whether the person is paid for his or her efforts. This definition draws on the market value of the activity rather than the social role or the intrinsic value of the occupation (Freidson, 1994). This criterion is a simplistic notion of professional and is difficult to use as a distinction. For example, does the child whose nice aunt gives him a dollar for pieces of refrigerator art become a professional artist?

Amateur v. Professional: Based on this second variation of professional, one asks what is the difference between a professional health ethicist and the amateur? Ethics "is a generic human capacity" that all humans are capable of doing and which they do on a regular basis (Churchill, 1999, para 17). The issue of who is and who is not a professional health ethicist is a recent one (DeVries, Turner, Orfali, & Bosk, 2006; Magnus, 2001, 2002). According to Kayhan Parsi, a health ethicist is someone who works as a clinical ethics consultant in a hospital, an academic educator in a health science setting, or as a researcher on health ethics issues (Parsi, 2005, p. 135). Some scholars have written that the specific jobs health ethicists hold are hospital ethicist, forensic ethicist, media darling, and advisor to government panels (DeVries et al., 2006). Health ethicists then are individuals who make a living sharing their health ethics expertise with others. Bob Baker suggests that the following are health ethicists:

> …administrators, clinicians and health professionals of all sorts, historians, lawyers, literary scholars, nurses, policy makers, philosophers, physicians, policy analysts, and policy makers, psychologists, religion scholars, scientists, social scientists, theologians, and others united by the common purpose of analyzing, consulting, researching, studying and attempting to address, mediate and offer ethical solutions or resolutions to actual or potential ethical problems arising in biomedicine, biomedical science and healthcare. (Baker, 2005, p. 33)

Baker's definition of a health ethicist is problematic. First, it takes a narrow notion of health as simply people involved with medicine and healthcare practice, thus leaving out people in public health. Second, his list of who is a health ethicist is extensive because he has to offer a comprehensive list of occupations. That is, he is telling people who identify primarily as something other than a health ethicist that they are indeed a health ethicist. The point is that a professional health ethicist in this vein is someone who is paid for his or her primary responsibility of being a health ethicist instead of primarily as a physician, nurse, attorney, clergy, sociologist, anthropologist, historian, and so on. As Judith Andre suggests, "bioethics cannot be simply a subset of medicine, nursing, or health care" (Andre, 2002, p. 25). The question which arises in this arena is what percentage of a person's income or time must derive from *health ethics practice* in order for him or her to be considered a professional health ethicist. If a person receives $100 for giving a one hour lecture on a topic of bioethical interest, has that person now become a professional health ethicist? If a palliative care specialist presents a poster at the annual ASBH meeting, is that person a professional health ethicist? If a humanities scholar teaches one course in health ethics per year and guest lectures in the medical school, but most of his or her work is teaching introduction to philosophy and writing about logic, is he or she a health ethicist?

Even if someone's work clearly falls within those tasks and activities which could be defined as *health ethics*, the question of being a professional health ethicist also hinges on whether people who do this work are paid as health ethicists or as something else. For example, a physician who makes his or her salary based on seeing patients or teaching physiology, but also serves on the ethics committee, is not a professional health ethicist, but a professional doctor who does some amateur health ethics. These individuals participate in many of the activities of health ethics but because they do not receive remuneration for those efforts, that person is not a professional. If one is a nurse who likes to read health ethics journals and attend a couple of talks, but receives no remuneration for those efforts, that person is then an amateur health ethicist. In another example, a volunteer community member of an institutional review board may receive a small stipend for time or transportation. Such a person is an amateur health ethicist since he or she is not being paid for health ethics expertise, but rather for being a voice of the community. That volunteer is not expected to have extensive training in health ethics or related disciplines. For the amateur, this work is a small, mostly unpaid, portion of the activities or tasks that he or she does within an average day.

This author suggests that in order to be classified as a professional health ethicist at least 51 percent of a person's income must derive from health ethics activities that are a primary part of his or her occupation. Such a measure is similar to the scholar who has a joint appointment in the Department of English and the Center for Bioethics. According to the rules of many universities,

the department to which the scholar reports and the department responsible for evaluation, tenure, and promotion is the department where the person has at least a 51 percent appointment. Thus, under the arena of distinguishing professionals and amateurs, the same criterion should apply.

Historical professionalization (process)
A third method of examining professionalism comes from examining the process by which the traditional professions—law and medicine mainly, the clergy secondarily—gained their stature. This approach is taken by Magali Sarfatti Larson who traces the organization of occupations into professions from pre-industrial times as an economic interest and as a force against bureaucracy (Larson, 1977). Harold Wilensky also offers a similar historical exploration. His goal was to examine the stories, by which occupations professionalize, a task which very few occupations achieve. He explains a model of professionalization with five stages including (1) full-time work, (2) creating requirements for education, (3) establishing professional associations, (4) establishing government licensure, and (5) adopting a code of ethics (Wilensky, 1964, pp. 142-146). The stages, however, should not be used as a litmus test, but simply an examination of an historical process.

Education: Deborah Cummins uses Wilensky as a litmus test when she says that health ethics consultation meets the third stage of establishing professional associations and is beginning to meet the second stage of educational requirements by establishing masters and doctoral programs (Cummins, 2002). She assumes that Wilensky provides a roadmap when he is actually describing what has been. A 2001 ASBH report described 108 degree programs (63 masters, 19 doctorate, 13 fellowship, 11 certificate, and 2 other) at 47 participating institutions (ASBH Status of the Field Committee, 2001). In the 1970s, 4 bioethics programs were established, in the 1980s 19 programs, and in the 1990s 42 programs. In the academic year 1999-2000, 242 students graduated from bioethics and medical humanities programs (ASBH Status of the Field Committee, 2001). Data for the 21st century is not available. During that same time, only 1 in 4 students was able to secure a full-time job in bioethics (Bosk, 2002). Thus, Bosk points out, bioethics may be turning out an increasing number of graduate students who have a small chance of ever working in the field (Bosk, 2002).

Whether a degree in health ethics is sufficient to be a professional health ethicist is controversial. Mere possession of a health ethics degree without some other disciplinary degree or experience will not secure a job (Magnus, 2002).The first and second opening scenarios to this essay demonstrate that some believe a specific degree—usually the same degree that the speaker has—is necessary to do health ethics. On the other hand, DeVries and Conrad believe that a health ethics degree will become a necessary credential to be able to practice health ethics (DeVries & Conrad, 1998). Kayhan Parsi suggests:

> The profession of bioethics requires that its members be well-educated in general ethics principles, have a familiarity with law, history and clinical terminology, and also be proficient in interpersonal skills (such as negotiation, interviewing, etc.). (Parsi, 2005, p. 141)

Thus, a person could have any degree or credential as long as he or she had these skills. Parsi's statement neglects that the "profession of bioethics" may not exist and certainly does not have a singular, coherent voice. Also, training programs do not agree in regards to what knowledge, skills, and disciplinary experiences a health ethicist needs. The 2001 report stated that faculty come from a variety of disciplines including philosophy (20% of faculty), medicine (15%), law (14%), theology/religious studies (12%), nursing (10%), history (6%), behavioral/mental health (5%), sociology 4%), English/literature (4%), public health (4%), social work (2%), and other (2%) (ASBH Status of the Field Committee, 2001). Noticeably lacking from this list is "health ethics," "bioethics," or "medical humanities." The health ethics profession also lacks any requirement for continuing education as there is in medicine, law, nursing, and social work. Health ethicists may continue learning, but that is of their own desire and not because of professional requirement

While a specific degree is not required, the degree held has an effect on salary. The results of a 2008 ASBH salary survey are in Table 1. This data clearly shows that those with traditional "professional" degrees earn more money than those with academic or education degrees.

Table 1: Salary by degree (Kaup 2008)

Degree	Salary
MD/DO	$159,337
DDS/DMD	$123,500
JD	$101,626
PhD	$96,248
MS/MA	$92,367
EdD	$86,117

The effect of professionalizing health ethics or in requiring a terminal degree in health ethics on salary can not be predicted.

Professional Organization: The idea of forming professional organizations has been a significant and controversial part of the development of professional health ethics. In 1968, the Society for Health & Human Values was created. However, individuals who identified themselves as mainly clinical practitioners or as philosophers were not satisfied with this group. The Society for Bioethics Consultation incorporated in 1986 to deal with the concerns of clinical ethics consultants. Then in 1994, the American Association of Bioethics was formed by philosophers. In 1998, these three groups came together to form the American Society for Bioethics and Humanities (Andre, 2002; Kozishek, 2006).

Specialized Knowledge: As the first opening scenario demonstrates, the knowledge set of health ethics is largely borrowed from other fields including law, medicine, philosophy, literature, history, and many others. Even the classic health ethics cases are really legal cases that health ethics borrowed as part of its founding mythology. As Andre says, the knowledge of health ethics has to be shallow because it must be understood by people from many different disciplines, fields, and walks of life (Andre, 2002). The language of health ethics borrows from its constituent disciplines and must be nonspecific enough to be understood by people from many occupations. Another aspect of specialized knowledge is the presence of forums for the creation

and sharing of new knowledge such as the annual ASBH meeting and Bioethics Summer Retreat as well as dozens of academic, peer-reviewed journals that appeal to various audiences within the larger ASBH organization.

Code of Ethics: Recent discussion has revolved around the creation and adoption of a code of ethics for clinical health ethics consultation. In fact, a significant portion of a 2005 issue of the American Journal of Bioethics examined Baker's proposed aggregated code of ethics. Baker suggests that health ethics has reached an historical point where a code is necessary to assert professional independence and integrity (Baker, 2005). Tom Beauchamp argues that health ethics may not be ready to create a code, because it is not quite clear who is a health ethicist yet and to whom the code would apply (Beauchamp, 2005). Bethany Spielman suggests that a professional code of ethics would be useful to create standards and define appropriate behavior for those involved in forensics—giving expert testimony in legal cases (Spielman, 2002).

From an historical perspective on professionalization, health ethics may be heading down that road (Cummins, 2002). At least the field has begun to follow the paths of many of the more traditional professions. However, the assumptions made by Cummins is that following along a similar path to gaining the characteristics of a profession will (a) make health ethics a profession in the public's eye and (b) is an endpoint for which health ethics should strive. Even if a field has gone through similar processes of the traditional professions does not mean it is on its way to being a profession.

Jurisdictions (process)

A fourth perspective looks at professionalization as a separation of *us* from *them*. Andrew Abbott defines professionalization as a process whereby an occupation successfully wins control over a certain set of work activities (Abbott, 1988). Abbott states that the tasks of professions are to provide expert service to attend to human problems (Abbott, 1988). Although he takes an historical approach in discovering his method, he focuses on the "jurisdictions" which an occupation controls. He rejects the idea of a sequence of developmental events which lead to professionalization, but instead suggests that one should focus on the "jurisdictional disputes" (Abbott, 1988, p. 2). Abbott lists the jurisdictions over which an occupation must gain control: (1) practical knowledge and professional associations, (2) work sites, and (3) scientific productivity. The efforts begin at a local (individual) level and then expand into the state (systemic) level (Abbott, 1988).

Health Ethics' Jurisdiction: This perspective requires one to ask if health ethics has taken control of a jurisdiction. The second scenario that opened this paper talked about the question of whether physicians or humanists should be doing clinical consultation. Cummins believes that the battle for jurisdictional control is happening with clinical ethics taking control of knowledge and skills for complex medical decision making away from physicians (Cummins, 2002). DeVries et al. identified this jurisdictional battle through an ethos that "denigrate[s] moral insights of concerned, thoughtful actors and attempt[s] to install themselves as uniquely qualified 'expert' arbiters of moral conduct" (DeVries et al., 2006, pp., 673). Ruth Shalit and Wesley Smith wonder how health ethicists were able to seize the power to become the arbiters of ethical issues in medicine and health (Shalit, 1997; Smith, 2001). The notion of health ethics having

control over this arena is echoed by Charles Bosk: "What is significant here…is the public approval given to the idea that what is wrong with health care is somehow connected to ethics and that such problems are best fixed by ethicists" (Bosk, 1999, para 18). Bosk criticizes this movement, saying that there is no basis for the legitimacy of the moral authority of the health ethicist, since it is a role that lacks historical origin. Thus, rather than a territory that health ethics conquered, he suggests that this arena was forced on health ethicists when patients suddenly found themselves needing to make more decisions in their health care as part of the patient autonomy movement.

If health ethicists become responsible for all ethics activities, then the public perception may be that health ethicists are not guides to moral deliberation and patient advocates but rather are the ethics police. Once given the public and legal mandate for control over ethical issues, must health ethicists then defend their territory and enforce their judgments? Would health ethicists have to spy on others to see if their behavior is ethical? Carl Elliott believes that many people who work in the field of health ethics resist the notion of professionalization for just this reason (Elliott, 2005b).

Worksites: Another concern is that health ethicists rarely work on their own turf. Ethicists work in a variety of sites including medical schools, health care facilities, universities and colleges, non-governmental organizations, nursing schools, public health schools, allied health schools, law schools, private practice, community colleges, dental schools, and community health agencies (Kaup 2008). The worker who primarily identifies as a health ethicist has no homeland, and is always working as a guest elsewhere. Rather than carving out new territory, health ethics has simply become one more medical specialty (Bosk, 1999; Elliott, 2005b) with allegiance to whomever is paying for services (Spielman, 2005). "Bioethics may not be sufficiently developed to count as a full-fledged practice" (Andre, 2002, p. 61). Under a jurisdictional examination of health ethics, the field is clearly not a profession.

Social and Economic Power (process)

A fifth approach suggests that the story of the professions is a battle for social and economic power. Vincent Navarro claims medicine evolved into a profession through a conflict between class, gender, race and power relationships (Navarro, 1988). Don Kirschner studies the public service professions and proposes that their rise is related to tensions between the capitalist classes and the rise of experts pushing for social change (Kirschner, 1986).

Everett Hughes says in the same vein that professionalization "is in part a study of social advancement (mobility)" (Hughes, 1960, p. 56). The goal of a professionalized occupation is autonomy of its work, solidarity of its members, and standardization of practice. To be a professional means that an individual has a higher ranking among all occupations. The desire to professionalize has two parts according to Hughes. The first is that an individual desires to socially advance by being a member of a prestigious occupation. The second desire is "the collective effort of an organized occupation to improve its place and increase its power, in relation to others" (Hughes, 1960, p. 56). The way that an occupation usually becomes a profession is (a) by requiring additional education of its members, (b) by self definition of proper work, (c) by placing "mundane duties on the shoulders of subordinate workers," (Hughes, 1960,

p. 57) (d) by "claiming a mandate to define the public interest in matters relating to their work" (Hughes, 1960, p. 57), and (e) by undertaking research in its area of professed expertise.

Focus of Work: Some critics have suggested that one of the problems with health ethics is its focus on the patient-provider encounter and neglect of larger issues of power, race, gender, and justice (Andre, 2002; Bosk, 1999; Churchill, 1999; DeVries et al., 2006). Thus, if the rise of a profession is a battle for social justice, then health ethics has simply not even stepped onto the main battlefield. A longstanding debate within ASBH has held that organization to the standard of not holding and publicizing positions on any issue beyond those of academic freedom. Thus, health ethics is still viewed as just part of the medical bureaucracy, rather than something new or challenging to the status quo (Elliott, 2005b).

Research: Many of the professionalism theorists cite the creation of new knowledge, intellectual innovation, or research as among the hallmarks of a profession. Certainly health ethics has embraced the notion of research into its jurisdictional areas, its practices, and clinical knowledge. Research methods range from case studies to new theories, policy analysis, empirical studies, and examination of the field itself. This new information is disseminated in a large number of journals and academic conferences. For those employed in universities or academic medical centers, there is an increasing demand for research that will bring in grant dollars and institutional prestige. In the author's interview presented in the second opening scenario, the institution made clear that health ethics activities were required to generate 80 percent of their costs including salaries. In these same settings, promotion, tenure, and raises are based more on conducting research and scholarship than on teaching and service.

Elliot suggests that in academic settings, there are increasingly higher expectations for health ethics units to fund themselves through clinical service and grants, rather than being a cost center (2005, p. 383). In fact, Churchill believes that health ethics will be judged more and more on its market value in health care (Churchill, 1999). The result of a greater focus on money is that health ethicists are likely to be coerced in choice of research topics and decision-making based on who is paying (Elliott, 1998). The topics that commonly fall under health ethics tend to be ones chosen for the field because it is of interest to those in power (i.e. physicians, administrators) or to those who pay health ethicists' salaries. Bioethical issues are sometimes chosen because they are current issues in the media or legislatures, or because those are the topics that foundations and agencies will grant fund (Andre, 2002).

Virtues and Traits (descriptive)

A sixth approach takes a virtue or valued traits approach. According to William Goode, professions require a lengthy period of education in specialized knowledge and an orientation toward serving others (1957). In the literature on professionalism, one tends to see an "either or" perspective: Either an occupation is a profession or it is not. Instead, Goode suggests that one should view occupations along a "profession continuum." He says that where an occupation falls on the continuum depends on how many of the ten traits it has:

(1) "The profession determines its own standards of education and training.
(2) The student professional goes through a more far-reaching adult socialization experience then the learner in other occupations.

(3) Professional practice is often legally recognized by some form of licensure.
(4) Licensing and admission boards are manned by members of the profession.
(5) Most legislation concerned with the profession is shaped by that profession.
(6) The occupation gains in income, power, and prestige ranking, and can demand higher caliber students.
(7) The practitioner is relatively free of lay evaluation and control.
(8) The norms of practice enforced by the professions are more stringent than legal controls.
(9) Members are more strongly identified and affiliated with the profession than are members of other occupations with theirs.
(10) The profession is more likely to be a terminal occupation. Members do not care to leave it, and higher proportions assert that if they had it to do over again, they would again choose that type of work". (Goode, 1960, p. 903).

On one end of Goode's continuum are occupations that meet none of the traits such as unskilled workers. On the other end, are the traditional professions of medicine and law representing a model autonomous professional community?

Another virtues scholar, Robin S. Downie offers a list of necessary "family resemblances" of professions that includes (1) a knowledge base that draws on several disciplines, (2) a concern "through beneficence coupled with integrity, to promote the interests of his clients...restrained by ethical and legal bonds" (Downie, 1990, p. 153), (3) "the duty to speak out with authority on matters of social justice and social utility" (Downie, 1990, p. 153), (4) independence to fulfill its social roles (Downie, 1990, p. 153), (5) educated practitioners who see the big picture, holds a specified "framework of values" (Downie, 1990, p. 154) and pursues continuing education, and (6) legitimacy through professional autonomy. Such autonomy includes a public perception of professional independence, internal discipline, pursuit of knowledge, and concern for practitioner's education (Downie, 1990, p. 154). Downie suggests that these resemblances are ideal characteristics of a profession, not defining criteria.

Although recognizing the difficulty of defining professionalism, Freidson offers a loose trait-based definition of profession. He acknowledges that his definition is extremely broad, focusing on concepts of control, community, and dedication to work and service: "I use the word 'profession" to refer to an occupation that controls its own work, organized by a special set of institutions sustained in part by a particular ideology of expertise and service" (Freidson, 1994, p. 10). In addition, Freidson also offers several virtues which he believes are held by most professions: (1) Occupational commitment, (2) occupational organization, (3) dedication to the work, (4) superior skillfulness (i.e. expertise), (5) credentialing, (6) professional autonomy, and (7) intellectual innovation (Freidson, 1994, pp. 122-125, 154-166, 175-179). When an occupation has most of these traits it gains professional dominance—control of the production of knowledge, division of labor, provision of services, and self organization. In other words, the occupation gains/earns/takes a monopolistic control over its area of claimed expertise (Freidson, 1970).

Long Adult Socialization: Practicing health ethicists usually have a terminal doctoral degree, requiring many years of formalized education. In addition, the person might have an apprentice

or fellowship experience. One can become known as a *health ethicist* through two methods: "(1) acknowledgement by peers and (2) "broader public acceptance of one's authority in 'bioethical' matters" (DeVries & Conrad, 1998, p. 238). But if someone did not care about respect of peers or contributing to intellectual discussion and growth, nothing would prevent that person from claiming the title professional health ethicist.

Professional Autonomy: One of the hallmark traits of a profession is that of professional autonomy. This trait includes independence from outside influence, internal discipline of members, a service orientation, and a dedication to pursuit of knowledge. Many of these issues have already been discussed in this paper. According to Andre, the goal of health ethics is to help direct public attention to ethical issues and to promote wiser thinking about health matters (Andre, 2002). Churchill states that while health ethicists do work in the public interest through speaking engagements, teaching, and service on government panels, he believes that this service is to a limited segment of the population (Churchill, 1999). Therefore, even though health ethics may engage in some service to society, its arena is very small and as mentioned earlier, neglects larger issues of social and economic justice.

Licensure: This same notion of control over who gets to be a professional health ethicist relates to the notion of government sanctioned licensure. Without licensure or an accrediting body, there is no way to prevent someone from calling him or herself a health ethicist or of challenging that claim once made (DeVries et al., 2006). Andre suggests that licensure would limit the activities a health ethicist could undertake in regard to teaching, consultation (service), or research (Andre, 2002). If the field cannot even define who is a health ethicist, then how can a field grant practice licenses to individuals? If academic curriculums cannot decide on necessary skills and knowledge, then how can a license, which denotes to the public an expertise with these skills and knowledge sets, be taken seriously? Some of the resistance to licensure has also revolved around the idea that health ethics traditionally has been an interdisciplinary endeavor where everyone with an interest in certain topics is permitted to come under the tent. To be more profession-like, is health ethics ready to close the doors on the tent? Such standardization and limitation is likely to lead to a decrease in the dynamic interdisciplinary nature of the field.

Legislation: Do health ethicists control legislation dealing with the profession? Health ethicists and those who work on bioethical issues are often involved in legislative efforts. From writing amicus briefs on court cases, to serving on local, state, and national advisory panels, to sponsoring legislative bills, health ethicists have worked for legislative change. But, such change is usually related to issues such as cloning, stem cell research, end of life care, and advance directives. Rarely are laws passed that effect health ethics practice or that require health ethicists involvement with policy. There are some exceptions. In Texas, the "futility law" requires ethics committee review of cases, but does not require a health ethicist to be involved. The Nevada Center for Ethics & Health Policy was instrumental in writing and helping pass the Nevada on-line advance directive registry act. The Joint Commission for the Accreditation of Hospital Organizations (JCAHO) does require some mechanism for resolution of ethics issues such as an ethics committee or ethics consultation service. JCAHO does not, however, require a trained health ethicist to be on staff. Health ethics lacks this professional trait.

Prestige: Another virtue deals with the idea that being a profession will lead to increases in income, power, and prestige. According to Andre, "…bioethics can offer a certain degree of celebrity, if one is quoted in the media or does much public speaking" (Andre, 2002, p. 73). Being a health ethicist may indeed increase an individual's prestige and public power because one's words and ideas are heard widely and are believed to have importance.

While power and prestige can be difficult to measure, income information is available. A 2006-2007 report by the American Association of University Professors is summarized in Table 2 alongside recent salary data for full-time health ethicists.

Table 2: Salary comparisons (Smallwood 2006; Kaup 2008)

Field or location	**Professor**	**Associate professor**	**Assistant professor**
4 year universities	$98,974	$69,911	$58,662
Health science centers	$108,900	$82,250	$69,500
Biomedical & biological sciences	$90,040	$63,929	$54,101
Humanities	$74,228	$59,982	$48,635
Philosophy & religious studies	$82,030	$59,429	$48,162
Health ethics (full-time)	*$130,750*	*$105,644*	*$85,914*

On average, the health ethicist makes a higher salary than non-health ethicist colleagues. Thus, there is a salary increase associated with being part of this occupational field. Thus in terms of power, prestige, and salary, health ethics fills this criterion of being a profession.

Free of Lay Control and Evaluation: As has been discussed throughout this paper, health ethics is not free of lay control. Health ethics is shaped by outside power sources: "Bioethicsts will not represent an independent voice in the discussion of the uses of medical power" (DeVries & Conrad, 1998, p. 239). Medicine and nursing often have state boards which are responsible for investigating complaints against their professionals and for imposing sanctions. Such mechanisms do not exist in the field of health ethics. Sanctions and governance are done by the other professions to which health ethicists belong or by lay groups.

On the Continuum: Using Goode's profession continuum, one sees that health ethics has four of the traits –long socialization, shapes legislation, prestige, and perhaps terminal occupation. On the other six virtues, health ethics does not reflect the trait—control of education, legal licensure, control of licensing and admission boards, free of lay control, enforced norms of practice, and strong primary identification. On Goode's profession continuum, health ethics has only 4 out of 10 traits, meaning it is closer to the middle of the spectrum.

Looking at health ethics

In most of the health ethics writing about professionalism, the assumption is made that if you adopt the list of traits, follow the historical path, or carve out a jurisdiction, then health ethics will become a profession. One should not assume, however, that simply meeting a list of characteristics will make an occupation or a field a profession. These theories suggest a series of

traits and processes which are necessary to the professions, but these traits and processes are not sufficient to become a profession. Occupations become professions through accidents of history or through prolonged efforts over a period of time. As a new field and occupation, health ethics has not had the time for professionalization to occur. All of these articles assume that professionalization is a choice; something that an occupation can decide it wants and then pursue. Looking at the efforts of such occupations as nursing or journalism to professionalize shows that adopting a set of traits or making a declaration is hardly sufficient to become a profession (Bradley, 2000; Merrill, 1974). Freidson argues that an occupation needs to also win over a "political, economic and social elite" (Freidson, 1970, p. 188) as well as gain the trust of the general public. The public must see the members of the profession as necessary experts in its specialized area (Freidson, 1970). Navarro and Hughes suggest that it will be harder for new professions to achieve professional stature and for old ones to maintain it (Hughes, 1960; Navarro, 1988). The locus of control for professionalization is outside of the occupation. Thus health ethics cannot *decide* to become a profession.

From a process perspective, health ethics cannot become a profession because it missed the historical boat and has failed to secure a social and economic monopoly over a jurisdiction of knowledge and skill. A descriptive perspective suggests that health ethics is on course to becoming a profession because it has adopted many of the criteria (excellence; payment; traits) that define a profession. This more simplistic point of view holds that a field or occupation can become a profession when it has adopted all of the traits. As this discussion has shown, however, health ethics is clearly not yet a profession from either a process or a descriptive standpoint.

Assuming for the moment that health ethics could choose to professionalize, the question remains whether the field ought to professionalize. Many scholars have written in favor of professionalization (Baker, Cummins, Parsi, and Spielman). Arguments in favor cite greater external prestige for health ethicists in their work settings, standardized work roles in clinical and legal settings, and standards which define appropriate activities and provide a basis for judging work competency as well as control over who can lay claim to the title. On the other side, many have written against the idea of professionalization (Andre, Beauchamp, Churchill, and Elliot) because such a move limits the field and who can practice. In the end, professionalization does not provide an advantage to those who work as doctors or nurses or researchers and who also do ethics. The benefit is for the small subset of individuals who make their living as clinical ethicists in health centers who work in a world where professionalization and credentialing offer prestige, caché, and a perceived moral right to be on the scene. The major benefit would be some control over who would get to lay claim to the title of "health ethicist" (i.e. claiming a jurisdiction and controlling entry into the field). The current open-ended approach where anyone is welcome is clearly bothersome to those who feel a certain background or basic education should be necessary. For example, in my own experience of working with a self proclaimed "ethicist," his orientation was in dictating to people what he knew to be the right thing to do in every situation, based on his strong faith tradition. My approach was to empower people to make their own choices by being a protector of the process of moral deliberation. We were both equally annoyed that the other claimed to be an "ethicist" because both believed that the other was doing the work poorly and was a bad representative of the title. With a controlled approach to who gets to be a health ethicist, someone or some ideology has to decide what the professional

approach, education, is and skill set that ordained ethicists should have. The other “ethicist” and I would obviously disagree, which leaves the question as to who should decide.

The true benefit to this examination is a reflective exercise on the social status and function of the field. For example, one lesson might be that health ethics adopts a broader social justice perspective that is often required of traditional professions. However, professional status in and of itself should not be a goal except for the clinical health ethicist. The result of the standardization and control necessary to be profession-like would remove the dynamic, interdisciplinary, multi-perspective attributes that have made health ethics such an exciting field. It would be a shame to lose that youthful exuberance to become just another medical or legal specialty in the bureaucracy. Some writers even claim that the professions are in decline (Navarro, 1988), why would health ethics want to join a sinking ship? Instead of trying to conform to historical models, health ethics should strive to be something new. Health ethics can look to the past for guidance and suggestions, but it needs to forge its own future.

References

AAUP. (2006-2007). *Report on the Economic Status of the Profession.* Retrieved September 30, 2007, from http://www.aaup.org/AAUP/comm/rep/Z/ecstatreport2006-07

Abbott, A. (1988). *The System of Professions: An Essay on the Division of Expert Labor. Chicago:* University of Chicago Press.

Andre, J. (2002). *Bioethics as Practice.* Chapel Hill, NC: University of North Carolina Press.

ASBH Status of the Field Committee. (2001). *North American Graduate Bioethics and Medical Humanities Training Program Survey.* Glenview, IL: American Society for Bioethics and Humanities.

Baker, R. (2005). A draft model aggregated code of ethics for bioethicists. *American Journal of Bioethics, 5*(5), 33-41.

Bayles, M. D. (1981). *Professional Ethics.* Belmont, CA: Wadsworth

Beauchamp, T. L. (2005). What can a model professional code for bioethics hope to achieve. *American Journal of Bioethics, 5*(5), 42-43.

Bosk, C. L. (1999). Professional ethicist available: Logical, secular, friendly. *Daedalus, 128*(4), 47-68.

Bosk, C. L. (2002). Now that we have the data, what was the question. *American Journal of Bioethics, 2*(4), 21-23.

Bradley, C. (2000). Profession or Trade: It's up to nurses to answer the question [Electronic Version]. *Nursing Week.* Retrieved February 1, 2008, from http://www.nurseweek.com/ednote/00/100900.html.

Churchill, L. R. (1999). Are we professionals? A critical look at the social role of bioethics. *Daedalus, 128*(4), 253-274.

Cummins, D. (2002). The professional status of bioethics consultation. *Theoretical Medicine and Bioethics, 23*(1), 19-43.

Derse, A. R. (2005). ASBH Presidential Forum: The seven-year itch. *American Journal of Bioethics, 5*(5), 1-5.

DeVries, R., & Conrad, P. (1998). Why bioethics needs sociology. In R. DeVries & J. Subedi (Eds.), *Bioethics and Society Constructing the Ethical Enterprise* (pp. 233-257). Upper Saddle River, NJ: Prentice Hall.

DeVries, R., Turner, L., Orfali, K., & Bosk, C. (2006). *Social science and bioethics: The way forward. Sociology of Health & Illness, 28*(6), 665-677.

Downie, R. S. (1990). Professions and professionalism. *Journal of Philosophy of Education, 24*(2), 147-159.

Elliott, C. (1998). A *Philosophical Disease: Bioethics, Culture, and Identity (Reflective Bioethics)*. New York: Routledge.

Elliott, C. (2005a). Should journals publish industry-funded bioethics articles? *Lancet, 366*(9483), 422-424.

Elliott, C. (2005b). *The soul of a new machine: Bioethicists in the bureaucracy.* Cambridge Quarterly of Healthcare Ethics, 14, 379-384.

Freidson, E. (1970). *Professional Dominance: The Social Structure of Medical Care.* Chicago: University of Chicago Press.

Freidson, E. (1994). *Professionalism Reborn: Theory, Prophecy and Policy.* Chicago: University of Chicago Press.

Goode, W. J. (1957). Community within a community: *The Professions. American Sociological Review, 22*(2), 194-200.

Goode, W. J. (1960). The Profession: Reports and Opinion. *American Sociological Review, 25*(6), 902-965.

Hughes, E. C. (1960). The Professions in society. *The Canadian Journal of Economics and Political Science, 26*(1), 54-61.

Kaup, J. (2008). Salary Survey. Chicago: *American Society for Bioethics & Humanities.* Retrieved October 10, 2008, from http://www.asbh.org/membership/pdfs/salry.pdf.

Kirschner, D. S. (1986). *The Paradox of Professionalism Reform and Public Service in Urban America 1900-1940.* Westport, CT: Greenwood Press.

Kopelman, L. M. (1998). Bioethics and humanities: What makes us one field? *Journal of Medicine and Philosophy, 23,* 356-368.

Kozishek, D. M. (2006). *History of ASBH.* Retrived February 1, 2008, from http://www.asbh.org/about/history/ASBH_History.pdf

Larson, M. S. (1977). *The rise of professionalism: A sociological analysis.* Berkeley, CA: University of California Press.

Magnus, D. (2001). Bioethics programs evolve as they grow. *Nature Biotechnology, 19*(10), 991-992.

Magnus, D. (2002). The Meaning of Graduate Education for Bioethics. *American Journal of Bioethics, 2*(4), 10-12.

Merrill, J. C. (1974). *The Imperative of Freedom.* New York: Hastings House.

Navarro, V. (1988). Professional dominance or proletarianization?: Neither. *The Milbank Quarterly, 66*(Suppl 2), 57-75.

O'Donnell, W. (1967). Is Social Insurance a Profession? *Journal of Risk and Insurance, 34*(3), 417-422.

Parsi, K. (2005). Bioethics consultation in the private sector: *What is an appropriate model. HEC Forum, 17*(2), 133-145.

Shalit, R. (1997). When We Were Philosopher Kings. *The New Republic* (28 April), 24-28.

SHHC-SBC Task Force on Standards for Bioethics Consultation. (1998). *Core Competencies for Health Care Ethics Consultation.* Glenview, IL: American Society for Bioethics and Humanities.

Smallwood, S. (2006). Faculty salaries rise by 3.4%; law professors still earn the most. *The Chronicle of Higher Education, 52*(27), A12.

Smith, W. J. (2001). Culture of Death: The Assault on Medical Ethics in America. *USA: Encounter.*

Spielman, B. J. (2002). Professionalism in forensic bioethics. *The Journal of Law, Medicine & Ethics, 30*(3), 420-439.

Spielman, B. J. (2005). Professional independence and corporate employment in bioethics. *HEC Forum, 17*(2), 146-156.

Wilensky, H. L. (1964). The professionalization of everyone? *American Journal of Sociology, 70*(2), 137-158.

[i] While the author began his career as an anthropologist who studied bioethics, after completing a bioethics master's degree, he found it harder to be, in the tradition of Clifford Geertz, a participant-observer. Instead, he found that he had gone "native" and actually became a health ethicist. Thus, his perspective as an insider may not be completely objective.

[ii] The author uses the term *health ethics* as an umbrella term that encompasses *bioethics* (the academic study of moral decision-making in health and medicine), *medical ethics*, *nursing ethics*, *public health ethics*, and *clinical ethics*.