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Is Bioethics A Profession?

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Abstract

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.

Keywords: Bioethics, Professionalism, Profession, Education, Organizations

A student pursuing simultaneous graduate degrees in bioethics and medical anthropology attends a mentoring breakfast with a respected, senior member of the bioethics 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 bioethics 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."

Both of the above scenarios actually happened to the author in his pursuit of becoming a "bioethicist."^{vi} What the three scenarios have in common, besides a protagonist, is that each asks the question of what it means to be a professional bioethicist. Must bioethicists come from certain disciplines? Or does it require specific degrees? And how does bioethics 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 those who practice an occupation a great deal of social standing and 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 the question as to whether bioethics was a profession. This small inquiry was part of a larger discussion of how bioethics and the humanities were brought together under

ASBH and the uneasy house in which these fields now live (Derse, 2005). The question is an important one as bioethics moves into the future. Even if bioethicists 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 Kinds" 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 is vast and draws on many theories as to how an occupation becomes a profession and what is required for an occupation to be considered a profession. It is difficult to define what a profession is and any definition put forth is unlikely to be widely accepted (Bayles, 1981; Freidson, 1994). The attempts at defining and describing *profession*, *professional*, and *professionalism* fall into 6 categories.

Excellence

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

The second way that the term professional is used is simply in performance for pay. That is 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 bioethicist and the amateur? After all, ethics “is a generic human capacity” that all humans are capable of doing and which they do on a regular basis (Churchill, 1999, pp., para 17). These are individuals who participate in many of the activities of bioethics 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 bioethics journals and attend a couple of talks, but receives no remuneration for those efforts, that person is then an amateur bioethicist. 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 bioethicist since he or she is not being paid for bioethics expertise, but rather for being a voice of the community. That volunteer also is not expected to have extensive training in bioethics or related disciplines, or to hold higher degrees. For the amateur, this work is a very small, mostly unpaid, portion of the activities or tasks that he or she does within an average day.

The issue of who is and who is not a professional bioethicist is a recent one (DeVries, Turner, Orfali, & Bosk, 2006; Magnus, 2001, 2002). According to Kayhan Parsi, a bioethicist 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, pp., 135). Some scholars have written that the specific jobs bioethicists hold are hospital ethicist, forensic ethicist, media

darling, and advisor to government panels (DeVries et al., 2006). Bioethicists then are individuals who make a living sharing their bioethics expertise with others. Bob Baker suggests that bioethicists are:

...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, pp., 33).

Judith Andre suggests that a bioethics practice is about “keeping moral space open, providing language and skills within it, identifying moral problems and helping create solutions for them” (Andre, 2002, pp., 69).

Part of the problem in defining who is a professional bioethicist is that without licensure or an accrediting body, there is no way to prevent someone from calling him or herself a bioethicist or of challenging that claim once made (DeVries et al., 2006). Raymond DeVries and Peter Conrad suggest that a bioethicist provides “an independent and reasoned voice in medical decision making”(DeVries & Conrad, 1998, pp., 234). More specifically, DeVries and Conrad suggest that the clinical bioethicist is similar to a social worker in that the practitioner’s activities are “Listening to patients (or staff), suggesting options, [and] finding new ways to reconcile individual and institutional agendas” (DeVries & Conrad, 1998, pp., 248).

Even if someone's work clearly falls within those tasks and activities which could be defined as *bioethics*, the question of being a professional bioethicist also hinges on whether people who do this work are paid as bioethicists 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 bioethicist, but a professional doctor who does some amateur bioethics. Even Baker's definition of a bioethicist 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 bioethicist 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 bioethicist that they are indeed a bioethicist. The point is that a professional bioethicist in this vein is someone who is paid for his or her primary responsibility of being a bioethicist instead of primarily as a physician, nurse, attorney, clergy, sociologist, anthropologist, historian, and so on. As Andre suggests, "bioethics cannot be simply a subset of medicine, nursing, or health care" (Andre, 2002, pp., 25). The question which arises in this arena is what percentage of a person's income or time must derive from *bioethics practice* in order for him or her to be considered a professional bioethicist. If a person receives \$100 for giving a one hour lecture on a topic of bioethical interest, has that person now become a professional bioethicist? If a palliative care specialist gives a poster at the annual ASBH meeting, is that person a professional bioethicist? If a humanities scholar teaches one course in bioethics 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 bioethicist?

This author suggests that in order to be classified as a professional bioethicist that at least 51 percent of a person's income must derive from bioethics activities and service 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

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 a historical process.

Education: Deborah Cummins uses Wilensky as a litmus test when she says that bioethics 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). 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 bioethics is sufficient to be a professional bioethicist is controversial. Certainly mere possession of a bioethics 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 bioethics. On the other hand, DeVries and Conrad believe that a bioethics degree will become a necessary credential to be able to practice bioethics (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, pp., 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 bioethicist 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 “bioethics” or “medical humanities,” the degrees for which these faculty’s students are preparing. Nor is any specific degree, experience, or knowledge set required. “The profession of bioethics” also lacks any requirement for continuing education as there is in medicine, law, nursing, and social work. Bioethicists may continue learning, but that is of their own desire and not because of an organized professional requirement

DeVries and Conrad also suggest that bioethics has been working to become a profession by developing standards, creating a unified professional association, and growing a unique body of knowledge (DeVries & Conrad, 1998). By standards, one could refer to the ASBH Core Competencies which detail the skill and knowledge set that a clinical ethics consultant should have (SHHC-SBC Task Force on Standards for Bioethics Consultation, 1998). However, Larry Churchill points out that the core competencies are not meant as an attempt to establish professional standards (Churchill, 1999).

Professional organization: The idea of forming professional organizations has been a significant and controversial part of the development of professional bioethics. 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). The ASBH has served as a spokesperson for the academic freedom of its members as well as organizing academic meetings and providing journals to members at a discount.

Specialized knowledge: The last part about a unique body of knowledge could be more difficult to substantiate. As the first opening scenario demonstrates, the knowledge set of bioethics is largely borrowed from other fields including law, medicine, philosophy, literature, history, and many others. Even the classic bioethics cases are really legal cases that bioethics borrowed as part of its founding mythology. As Andre says, the knowledge of bioethics 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 bioethics 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 bioethics 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 bioethics has reached an historical point where a code is necessary to assert professional independence and integrity (Baker, 2005). The creation of a code can be seen as a step toward professionalization. Tom Beauchamp argues that bioethics may not be ready to create a code, because it is not quite clear who is a bioethicist 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 (Speilman, 2002).

From a historical perspective on professionalization, bioethics 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 bioethics a profession in the public's eye and (b) is an endpoint for which bioethics should strive. Even if a field has many of the characteristics of a profession that does not mean it is on its way to being one or even that the public and government would view it as such.

Jurisdictions

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 amend 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, pp., 2). Abbott lists the jurisdictions over which an occupation must gain control: (1) practical knowledge and professional associations, (2) work sites, (3) scientific productivity. The efforts begin at a local (individual) level and then expand into the state (systemic) level (Abbott, 1988).

A critic of this jurisdictional perspective is Ivan Illich. In Limits to Medicine, Illich argues that professionalized medicine actually harms patients who are under its control. He also sees medicine as trying to take control of additional areas of life so that more problems are seen as requiring medical intervention. The result of this medicalization of life is that traditional cultural ways of dealing with death, pain, and sickness disappear (Illich, 1977). Thus, he views the professionalization of medicine as problematic since it encroaches on other spheres of meaning and control in everyday life encouraging dependence and discouraging individual autonomy. Illich's perspective would suggest that bioethics' attempt to professionalize would merely be for its own benefit, potentially lacking any altruistic intention.

Bioethics' jurisdiction: This perspective requires one to ask if bioethics has taken control of a jurisdiction and if that is a good thing. 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). As mentioned above, Ruth Shalit and Wesley Smith wonder how bioethicists were able to seize the power to become the arbiters of ethical issues in medicine and health (Shalit, 1997; Smith, 2001). The notion of bioethics 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, pp., para 18). Bosk

criticizes this movement, saying that there is no basis for the legitimacy of the moral authority of the bioethicist, since it is a role that lacks historical origin. Thus, rather than a territory that bioethics conquered, he suggests that this arena was forced on bioethicists when patients suddenly found themselves needing to make more decisions in their health care as part of the patient autonomy movement.

If bioethicists become responsible for all ethics activities, then the public perception may be that bioethicists 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 bioethicists then defend their territory and enforce their judgments? Would bioethicists have to spy on others to see if their behavior is ethical? Elliott believes that many people who work in the field of bioethics resist the notion of professionalization for just this reason (Elliott, 2005b).

Work sites: Another concern is that bioethicists rarely work on their own turf. Hospitals belong to physicians, nurses, and health administrators. The courts belong to judges and lawyers. Academic medical centers belong to health and medical scientists. Even bioethics centers are usually located in a hospital or academic health science setting. Therefore, the worker who primarily identifies as a bioethicist has no homeland, and is always working as a guest elsewhere. Rather than carving out new territory, bioethics has simply become one more medical specialty (Bosk, 1999; Elliott, 2005b) with allegiance to whoever is paying for services (Speilman, 2005). “Bioethics may not be sufficiently developed to count as a full-fledged practice” (Andre, 2002, pp., 61). Under a jurisdictional examination of bioethics, the field is clearly not a profession.

Social and Economic Power

A fifth approach suggests that the story of the professions is a battle for social and economic power. Vincent Navarro claims medicine as a profession evolved as a conflict between class, gender, race and power relationships. He ties this to a division of labor on the medical team that places the physician as the major force in medicine. Though, he believes this physician dominance has been in decline (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, pp., 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, pp., 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, pp., 57) (d) by “claiming a mandate to define the public interest in matters relating to their work” (Hughes, 1960, pp., 57), and (e) by undertaking research in its area of professed expertise. Hughes also states that professions tend to have two types of workers: (1) applied practitioners and (2) researchers, teachers, and administrators who are removed from practice (Hughes, 1960).

Focus of work: Some critics have suggested that one of the problems with bioethics is its focus on the individual level, medical 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 bioethics 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, bioethics 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 site the creation of new knowledge, intellectual innovation, or research as among the hallmarks of a profession. Certainly bioethics has embraced the notion of research into its jurisdictional areas, its practices, and clinical knowledge. Research methods range from case studies to new theories, to theoretical discussions, to policy analysis, to empirical studies, and to 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 bioethics 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.

Virtues and Traits

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 (Goode, 1957). In the literature on professionalism, one tends to see an “either or” perspective. The land of professionalization is seen as the endpoint of a journey. 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 than 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. The profession is more like to be a terminal occupation. Members do not care to leave it, and a higher proportion asserts that if they had it to do over again, they would again choose that type of work. (Goode, 1960, pp., 903)

Thus, one can view Goode's profession continuum as a spectrum. On one end 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 an ideal 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, pp., 153), (3) "the duty to speak out with authority on matters of social justice and social utility" (Downie, 1990, pp., 153), (4) independence to fulfill its social roles (Downie, 1990, pp., 153), (5) educated practitioners who see the big picture, holds a specified "framework of values" (Downie, 1990, pp., 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, pp., 154). Downie suggests that these resemblances are ideal characteristics of a profession, not defining criteria.

Although recognizing the difficulty of defining professionalism, Friedson 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, pp., 10). In addition, Friedson 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 dominancy—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: The process of becoming a bioethicist can require a long adult socialization to be a respected member of the bioethics community. Practicing bioethicists usually have a terminal doctoral degree, requiring many years of formalized education. One can become known as a *bioethicist* through two methods: “(1) acknowledgement by peers and (2) “broader public acceptance of one’s authority in ‘bioethical’ matters” (DeVries & Conrad, 1998, pp., 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 bioethicist. Lacking norms of practice means that the profession cannot enforce its will on others.

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 bioethics is to help direct public attention to ethical issues and to promote wiser thinking about health matters (Andre, 2002). Churchill states that while bioethicists 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 bioethics

may engage in some service to society, its arena is very small and as mentioned earlier, neglects large issues of social and economic justice.

Licensure: This same notion of control over who gets to be a professional bioethicist relates to the notion of government sanctioned licensure. Andre reports concerns that licensure would limit the activities a bioethicist could undertake in regard to teaching, therapy, or research (Andre, 2002). If the field cannot even define who is a bioethicist, 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 bioethics 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 bioethics 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 bioethicists control legislation dealing with the profession? Bioethicists 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, bioethicists 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 bioethics practice or that require bioethicists' involvement with policy. There are some exceptions. In Texas, the "futility law" requires ethics committee review of cases, but does not require a bioethicist to be involved. 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 bioethicist to be on staff. Bioethics also lacks this trait of professions.

Prestige: Another virtue deals with the idea that being a profession will lead to increases in income, power, and prestige. A report by the American Association of University Professors shows that the average salary for professors at 4-year universities is \$98,974 for professors, \$69,911 for associate professors, and \$58,662 for assistant professors. At health science centers, salaries are \$108,900 for professors, \$82,250 for associate professors, and \$69,500 for assistant professors (AAUP, 2006-2007). Faculty in the biomedical and biological sciences in 2006 earned \$90,040 for professors, \$63,929 for associate professors and \$54,101 for assistant professors. In the humanities, those salaries drop to \$74,228 for professors, \$59,982 for associate professors, and \$48,635 for assistant professors (Smallwood, 2006). In philosophy and religious studies, salaries are \$82,030 for professors, \$59,429 for associate professors, and \$48,162 for assistant professors (Smallwood, 2006). Humanities scholars working in bioethics centers in medical schools are likely to make higher salaries than if they were in university humanities departments. Physicians, however, working mainly in a bioethics center, are likely to see reduced income. The work site and reporting college of the bioethics center in which one works greatly influences salary.

Similar to the third opening scenario, Elliot suggests that in academic settings, there are increasingly higher expectations for bioethics units to fund themselves through clinical service and grants, rather than being a cost center (2005, p. 383). In fact, Churchill believes that bioethics 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 bioethicists 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 bioethics 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 bioethicists' 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). Brushing aside any questions of integrity or conflict of interest, bioethicists tend to run toward the places that offer some small amount of fame or funding.

“In addition, bioethics can offer a certain degree of celebrity, if one is quoted in the media or does much public speaking” (Andre, 2002, pp., 73). Therefore, bioethics does increase prestige and often income of the individual. Would professionalizing bioethics increase the status of this work even further? This author doubts it.

Free of lay control and evaluation: As has been discussed throughout this paper, bioethics is not free of lay control. Bioethics is shaped by outside power sources: “Bioethicists will not represent an independent voice in the discussion of the uses of medical power” (DeVries & Conrad, 1998, pp., 239). In their work, bioethicists are guests in their work sites and are often paid by people with agendas and interests apart from that of the bioethicist. Such confusion can be seen in the third opening scenario where a humanist bioethicist is being held accountable to health science standards. When working within an organization, any professional loses some autonomy, independence to choose clients, choice of work setting, and self imposed work standards (Hughes, 1960). Bioethicists who do work for private organizations or undertake consulting may have restrictions placed on their speech, both verbal and written. Consultants for medical and

pharmaceutical companies may have gag clauses in their contracts or may be forbidden from publishing on any work done for the company. Even when publication is permitted, the company may have the right to review and to edit (Speilman, 2005). Sometimes authors of academic journal articles and editorials have been paid or received an industry-sponsored grant for their work (Elliott, 2005a). Companies may use the fact that they had a bioethics consultant as part of a public relations campaign to increase their sales and visibility: Having a bioethics consultant says to the world that you are ethical (Elliott, 2005a; Speilman, 2005). Perhaps independent scholars can claim freedom from outside control if one discounts the influence of working toward tenure or trying to achieve grant funding. For the most part, those occupations which do bioethics works are not free of lay control.

On the continuum: Using Goode's profession continuum, one sees that bioethics has four of the traits –long socialization, shapes legislation, prestige, and perhaps terminal occupation. On the other six virtues, bioethics 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, bioethics has only 4 out of 10 traits, meaning it is closer to the middle of the spectrum.

Looking at Bioethics

In most of the bioethics 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 bioethics 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, bioethics 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). Friedson argues that an occupation needs to also win over a “political, economic and social elite” (Freidson, 1970, pp., 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 bioethics cannot decide to become a profession.

As this discussion has shown, bioethics is clearly not a profession. The remaining question is whether bioethics ought to aim to one. As has been demonstrated throughout this essay, many scholars have written in favor of professionalization (Baker, Cummins, Parsi, and Spielman,). Arguments in favor cite greater external prestige for bioethicists in their work settings, standardized work roles in clinical and legal settings, and developed standards which define appropriate activities and provide a basis for judging work competency. On the other side, many have written against the idea of professionalization (Andre, Beauchamp, Churchill, and Elliot) for the very same reasons. Specifically, the reasons for professionalization tend to revolve around the adoption of a code of ethics and standards. Creating a code may make sense when engaging in particular practice activities, but that is a far cry from a professional code that

applies to all bioethicists. For those who are researchers, teachers, or administrators, professionalizing does not have the same advantages and in fact imposes limitations on who can do the work of bioethics.

Examining the professional status of bioethics provides important lessons for the field. For example, bioethics should consider adopting a broader social justice perspective and provide guidelines to help those whose work occurs in non-bioethics territory. Professional status itself should not be a goal. The result of the standardization and control necessary to be profession-like would remove the dynamic, interdisciplinary, multi-perspective attributes that have made bioethics 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 bioethics want to join a sinking ship? Instead of trying to conform to historical models, bioethics should strive to be something new. Bioethics can look to the past for guidance and suggestions, but needs to forge its own future.

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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 bioethicist. Thus, his perspective as an insider may not be completely objective.