with that status. From there, Chapter 2 develops a method of ethics reasoning. Emphasizing ethics *reasoning* is, admittedly, in contrast to the approach most common to ethics texts, wherein readers are introduced to key thinkers, that is, the "he argued, and then *he* argued, and then *he* argued" approach. Readers are shown why these great thinkers are so interesting and important, and then, in each case, given a list of reasons as to why the theory will not work. Connections between the theories are typically treated as mere contrasts, not as areas of agreement. This too often produces a kind of roller-coaster effect: students read Aristotle and are convinced that he is right, until they read Kant and find him conclusive, and then Mill, and Ross, and Rawls, and so on. It is no surprise then that students often give up on theory: "If these really smart folks can't get it right, who am I to try to figure out the correct theory?" Ethics reasoning is thus reduced to mere or ad hoc reactions or, worse, to naive relativism.

Here, the goal is to give readers guidance in genuine practical ethics reasoning, while also emphasizing the best insights of all the major theorists. It is hoped that these insights will give readers ample opportunity to rely upon the approach they find most valuable. But I also stress that the grand insights provided by each of the major traditions in fact complement the others far more than they conflict. The method urges that, carefully done, in particular with sufficient attention to the complex array of facts present in any ethics issue, those insights can be melded into a process for making sense of tough ethical problems, even for finding better *answers* to those problems – better if not always best answers. No method, to my mind, can guarantee the latter, but it can distinctly narrow the choices, excluding those that are clearly wrong, and give good reasons in defense of a few, often a very few, better ones.

1 Historical Overview and Definitional Questions

"When you awaken you will feel fresh and relaxed – with absolutely no memory of changing my lightbulbs."

The Professional Ethics Toolkit, First Edition. Christopher Meyers.

Not only are there myriad ways in which the term "professional" is used, but there has also been a marked increase – nearly 700 percent – in published instances of the term between 1800 and 2008.[1] It has clearly become a common part of our vocabulary, though with mixed meanings.

To see why our definition of professionals – as experts skilled in the provision of vital services, who have a normative commitment to their clients' well-being – is key to an understanding of professional ethics, it helps to get a sense of how professions formally emerged in history. This review shows that the process of formal professionalization occurred for two key reasons:

1. There were vital needs that existing service systems did not adequately address. Medical practice, as we shall see, serves as the paradigm.
2. Professionalization enabled the relevant groups to assure clients that they can trust that their practitioner had the relevant expertise and ethical commitment.

Both of these brought obvious advantages to clients. They now had skilled practitioners to whom they could turn for assistance with vital needs, and there was a greater likelihood that those needs would be effectively addressed. Practitioners similarly benefited. They acquired a monopoly over their services, with corresponding increases in wealth, social status, and power.

Those benefits also motivated any number of service-driven activities to *claim* professional status; even without the state-sanctioned monopoly of licensing, to call oneself a professional is to lay claim to an associated cachet, with its economic and status benefits. Too often, however, this was a mere declaration, without the requisite training, skills, and normative commitment that were associated with the profession. Consider the near-ubiquitous self-designation as "professional" by everyone from gardeners to hairdressers to, yes, car salespeople.[2] And it is at the heart of the familiar expression "Prostitution is the oldest profession." The idea here is the largely sardonic one that people have been willing to pay for such services for as long

as there have been people. Regardless of whether the claim is historically accurate, prostitutes, as will soon become clear, meet very few of our criteria for professionalism, nor, for that matter, do most athletes, gardeners, beauticians, or car salespeople.

Furthermore, all too often even the groups that formally professionalized allowed power and status to get in the way of fulfilling their true professional commitments. This straying from the ethical foundations on which formal professions were built has led to a recent reinforcement of those foundations, demonstrated in reinvigorated ethics curricula in undergraduate and professional programs and books like this.

I acknowledge from the outset that our definition of a professional as an expert who is skilled in the provision of vital services and who retains a normative commitment to his clients' well-being – is somewhat artificial, especially given that the most common meaning in ordinary language attaches professionalism with *pay*: to be a professional, per ordinary language, is to be paid for those services. This is exemplified in the distinction between an *amateur* and a *professional* athlete in sports. The latter are paid to compete while the former do it, presumably, for the love of the game.

Although the compensation component is the most pertinent to the meaning employed in each of the examples noted above, there is also at least an implied understanding that the "professional" designation grants distinction. Such persons are *better than* their amateur counterparts; they have more experience-based expertise and are committed to an ethical norm that prioritizes clients' needs. In short, to self-designate in this way makes for great *marketing*. Such people believe, and probably rightly so, that when they promote themselves as professionals potential consumers of their services will at least unconsciously *trust* them to do well by them.

While such trust is often warranted regardless of whether the individual or company meets the formal criteria (section 1.2), there is no structural reason to *assume* that this going in, whereas with the formal professions, trust is the *default*. It is because the formal professions have emerged in human history in response to changing vital interests and with strict, carefully designed credentialing processes underlying their creation and continued practice.

That trust is often warranted regardless of formal status is, in fact, a key thesis of this chapter, indeed of the whole book. While our definition and associated criteria will allow us to easily identify definite professions, the concept will also admit of degrees, ranging from clear profession to marginal, emerging, or non-professional work activity. Furthermore, that someone meets the definitional criteria does not guarantee that she will always *act* professionally. I have, for example, known and worked with too many university professors who were at best marginally competent and who treated their student-clients as means to an end, whereas my long-time gardener is as skilled and as honest as the day is long; he has always done his job professionally, while those professors failed in the key normative criteria.

1.1 Some History

Backing up, then, who *were* the first professionals? Consider the root of the term "to *profess* about matters of vital importance." Hence the first professionals were spiritual advisers, who provided wisdom and guidance on an issue of, arguably, incalculable importance: one's relationship with the divine. And they did so from a socially sanctioned position of competent authority and thereby of *trust*. Their role also gave these early clergy social status; they were typically held in great esteem, often with the corresponding benefits of enhanced material comforts, features that continue to be common to contemporary professionals. Further, archeological records reveal that human cultures from the earliest times relied on such trusted and authoritative voices.

Once clergy – or more accurately, the learned, since members of this group were among the very few who received a formal education and were literate – started branching out into other areas of vital human interest, they sustained commitments to their original, if also evolving, religious foundations. For example, early medical practitioners, particularly in Egypt and the Far East, were as much religious clergy as they were physicians, and their medical practices were richly infused with religious ritual, side by side with empirically

and scientifically developed cures. Early educators had a similarly religious focus. For all the noise about Socrates' impiety, the charges against him were mainly about his corrupting the youth about the *wrong* gods, not about turning them into atheists. Plato similarly infused deeply and richly religious themes into all his dialogues.

1.1.1 The rising role of science

While this continuing religious influence in increasingly scientific enterprises helped the clergy retain power and status, conflict was inevitable. By definition (most) religious activities are rooted in faith, not in science, or at least not directly so. From the earliest days, thus, religion and science have had to decipher how to coexist, with science playing an ever-increasing role. In ancient Egypt, for example, the spectacular monuments to the god-kings – pyramids, temples, and the Great Sphinx – were made possible only by highly advanced mathematical and engineering skills. Ancient Greece and Rome also struggled with the growing separation between appeals to the supernatural and increased understanding of how the natural world works. That understanding, not religious belief, was what allowed for the creation of the extraordinary infrastructure – plumbing, roads, bridges, buildings – without which Rome would never have been able to sustain its far-reaching empire. The men (all historical evidence suggests that they were pretty much exclusively men) who created these structures also enjoyed high social status and relative wealth; they were the equivalent of our upper management.

Although much of European culture and academia regressed during the Middle Ages, even as clergy reinforced their hold on power, these early specialists – essentially proto-professionals – maintained a presence, largely through informal apprenticeships. People still needed, after all, buildings, roads, and water. They also needed help with legal, medical, and animal husbandry concerns. Loose organizations thus began to emerge, eventually promulgating variations on what we later came to recognize as the legal, medical, and veterinary professions.

Throughout this entire period, religious authority had a solid stranglehold on socially sanctioned "truth." Correct answers came from understanding God's will and only those who were properly trained in liturgical interpretation – and in the literacy skills needed to access written scripture – could claim such understanding. Heavenly inspiration even extended to the selection of monarchs; they were understood to have been chosen by God and thus carried the "divine right" to rule as they saw fit (the story of King Arthur, with his divinely enabled removal of the sword from the stone, is a popular depiction of this idea).

1.1.2 Impact of the European Enlightenment

These beliefs ultimately ran head on into the European Enlightenment, with its astonishing explosion of culture, education, scientific discovery, and political transformation. Exemplified in the work of Copernicus and Galileo, the scientific turn came to fruition in the ideas of people like Francis Bacon, with his defense of science as the path to truth (Bacon, 2008), and John Locke, with his rejection of the divinely inspired monarchy (Locke, 1988). These great thinkers helped motivate societies to turn to the scientific method to make sense of the world and to the inherent dignity of all persons as the foundation for governing structures. Add to this that, thanks to Gutenberg, written material could now be widely disseminated and you have the foundations for a newly educated and politically engaged citizenry.

Furthermore, Europe also saw a dramatic population explosion in the eighteenth century as a result of increased life spans and improved infant health, which came with the reinvention of water and sewage distribution (the systems perfected by the Romans had largely been abandoned after the fall of the empire). The mushrooming social structures, particularly those concentrated in cities, became increasingly complex, with a corresponding need for people to manage the associated infrastructure needs, including legal and political arrangements, science, and education.

In short, these major societal transformations created a whole new set of human needs, along with the need for associated experts – a

process that certainly continues today (consider, for example, the role of computing professionals relative to a mere forty years ago). The ranks of proto-professionals thus quickly expanded beyond clergy to include physicians, engineers, and lawyers. Further, while training for these proto-professions had previously been strictly through apprenticeship, universities increasingly took on that role, to the point that by the turn of the twentieth century, a college degree was considered the minimum prerequisite for professional training.

The largely mental expertise of these experts was both new to human society and in growing demand, enhancing their social status and economic standing even further. As with the clergy, the matters on which they practiced were of vital, if now more earthly, importance – for example, physical health, criminal and civil justice, and building safety. The client was thus deeply *dependent* on the expert: something critical to his well-being was at stake and he had little to no capacity to address it. Further, and again similar to the clergy's earlier position, he didn't even have the capacity to evaluate the expert's legitimacy other than through word of mouth and basic trust; the knowledge gap was just too wide.

It was no surprise that into that gap jumped opportunists, who were only too happy to take advantage of the fearful and needy. These schemers and scam artists – consider, for example, the origin of the term, "snake oil salesman" – claimed to have the same ability to fix your problems or cure your ills, and often far more cheaply. As often as not, though, they were just trying to swindle you out of your last dime.

1.1.3 Organizing to differentiate

Seeking a way to distinguish themselves from the fraudsters, those with legitimate proficiency determined that the best message was one of *structural* trust: "You can have confidence in us because we have created the structures – education, training, continuing oversight, and assurance of right character – that certify that we have the right skills and ethical commitment." These structures, and the formal bodies that came with them, provided a promise that their members were the real deal.

Medicine was the first to make this official move when the eventually named British Medical Association (BMA) was founded in 1832. Shortly thereafter, the association took on the role of determining the qualifications, including the right ethical standards, one must have to be deemed a physician. Not long after this, the association also developed the accrediting requirements for medical education in both classroom and residency settings. In short, the BMA was the first to create both the *credentialing* and the *curricular* standards that would assure the public that its members could be trusted.

The American Medical Association (AMA) followed suit in 1847, setting a normative stage at its inaugural meeting by establishing the association's first Code of Ethics. That act was intended to convince clients that its members were exceptional: it could be trusted both to have the requisite skills and knowledge *and* to have the promotion of its patients' interests as its primary motivation. It was also aimed at politicians, those who could, and soon would, grant it an economic and practice monopoly.

1.1.4 Formalizing the standards

Full adoption of credentialing and training criteria emerged in fits and starts, with the Flexner Report on US medical education (Flexner, 1910) serving as the key wake-up call for the need for strict nationwide standards. The result was a formal tightening of accreditation and apprenticeship requirements, producing the system of medical education, including residency programs, that we have today. Being a product of such a system, thus, gives one a kind of imprimatur: "You can trust me because I've received the system's approval." At the same time, the system motivated suspicion, if not cynicism, of those who were *not* members of the club. That suspicion was formalized when national and state legislators gave the AMA a monopoly over membership: they and only they could determine who should receive a license to practice.

The establishment of such confidence could occur, of course, only if members really *were* better, if the medicine they practiced was of a higher quality than could be found at the local barbershop.[3] This in turn motivated a more scientific approach to medical care and produced profound health-care advances, especially in pharmaceuticals. Hence we have ended up with a massive system, one that trains (both initially and through continuing education), ethically sorts and reinforces, self-regulates, and motivates the development of drugs and equipment.

To give a sense of just how enormous that system is, consider that the United States is expected to spend $3.35 trillion dollars on health care in 2016. That is more than $10,000 for every single person in the country. (Another way of thinking about just how much money we are talking about is to realize that you cannot count to even one trillion: assuming one number per second, twenty-four hours a day, it would take over 32,000 years to get to 1 trillion.) It should be no surprise, then, that even professionals of strong character and great training sometimes get seduced into pursuing profit at their clients' expense – a point we shall return to in the Epilogue.

1.1.5 Establishing trust

Even acknowledging the potential for corruption, it is important to recognize just how unusual and exceptional the professions' normative foundation is. Think about when you walk into your doctor's (or lawyer's or professor's or engineer's, for example) office. While you may have a healthy wariness, your overriding attitude is very likely one of *trust*. You trust them to know what they are doing – the license on the wall attests to those skills – and you trust that they are not going to order tests just to pad their bank account; instead, they will prioritize your well-being. Even though we generally take it as a given, such default confidence is in fact very striking; compare it, for example, with the attitude with which you likely approach a car purchase, where you assume that the salesperson is trying to make as much money off you as possible and, depending on local legal requirements, may not be fully honest about all a vehicle's quirks.

The vast majority of commercial relationships are, at their core, instrumental: each party is using the other to achieve an end, and suspicion about one another's motives is the norm. Hence, any modification to *caveat emptor* results from the parties having a pre-existing relationship, or is driven by the desire to create a long-term and mutually beneficial relationship, or is mandated by legal or regulatory oversight.

As we shall see, the structural conditions that create professional-client trust have taken some serious hits in the last few decades, but faith in the professional's basic normative foundation still prevails – and, for the most part, rightly so. That faith is the product of the *system* that socializes professionals through proper training, experience, oversight, and prioritization of client well-being; it is also explicitly present in the recognition that *individual professionals* have an ethical commitment to the relationship. They see their work as a *calling*, not just as a way to make a living; their very *identity* is largely defined by their professional role.

1.1.6 Monopolies, money, and power

The associated monopoly, however, along with the deep power asymmetry that typically exists between professional and client (one with expertise and exclusive access, the other typically vulnerable, fearful, and dependent) creates plenty of opportunity for abuse. Thus the formal arrangements established by the BMA and AMA had, from the outset, a built-in tension: on the one hand, they worked to protect patients' vital needs through the creation of real standards for what qualified as medical practice, while, on the other, they created an economic monopoly. The resulting power – legal power, knowledge power, and power rooted in sick or injured patients' vulnerability – made it easy for any given professional to exploit their status for personal enrichment, all while claiming a privileged standing. To balance this tension, the associations had to inculcate in their trainees, through classroom and especially residency training and mentorship, a deep commitment to a fundamental normativity. Physicians were socialized into thinking

of medical care as a calling and to dedicate themselves to the highest level of medical knowledge and to an avowed commitment to placing patients first.

While this structurally normative approach was hardly perfect – many physicians abuse the tremendous power attached to their role – it was largely successful in distinguishing authentically professional health-care practitioners from charlatans, and it was *very* successful in creating social status and wealth for its members. It is no surprise, thus, that it became the model for other budding professions like law, engineering, dentistry, veterinarians, accountants, and psychologists.

As I shall discuss in the Epilogue, however, this history took a turn in the 1980s, as the professions became, in William May's terms, "beleaguered," challenged by clients insisting on more control, by governments increasingly distrustful of the professions' ability to successfully self-regulate, and by businesses wanting a larger cut of the lucrative pie (May, 2001).

1.2 Defining "Professional"

In his influential book, *Professional Ethics*, Michael Bayles argues that the definition of key concepts – like "professional" – should emerge empirically, via a review of how the term is *used* in ordinary discourse (Bayles, 1981). As we have seen, however, that ordinary usage is now so broad as to include everyone, from those who are merely compensated for their services to those who assert – often for marketing purposes – a higher level of expertise, to those who have gone through extensive training so as to provide expert service on vital matters.

Given that the very goal of this book is to identify the special ethical considerations that distinguish the traditional professions, the ordinary language approach is clearly too inclusive. Thus, I prefer a *conceptual* approach, one that makes sense of what distinguishes these activities, in part by building upon the understanding gained through the historical analysis of the preceding section. That analysis shows us that activities like medicine and law *became* professions by

reacting to newly emerging vital needs and by formally defining the criteria necessary for being identified as a member of the group.

Central to those criteria is trust. The client must be able to trust the system to have granted an imprimatur only to those with proper training and character; he also needs to trust that a particular professional has the requisite skills and will not abuse her power by taking advantage of him emotionally, physically, or economically. He needs to trust that the professional is there *for him*, first and foremost, and not there just to make a buck. Professional colleagues also need a similar level of trust – again, in the system and in the individual – so as to feel confident about referrals or collaborative management of a client's problem.

For such trust to be present, a number of other necessary criteria must be satisfied, as they provide the structural conditions that make trust possible. Four of those criteria are *essential*, that is, all must be met, at least to a large degree, in order for the activity to be considered a formal profession. Others are common features that are typically present in traditional professional client relationships, generally as a consequence of the fulfillment of the essential criteria. Note also that there is a reciprocal relationship between the essential features and the core normative definition of trust that one's professional is a skilled expert committed to fulfilling clients' vital needs. The definition is *informed* by the criteria and at the same time *emerges* from them. That is, trust couldn't exist without the satisfaction of these criteria and, because professionals satisfy them, we trust them to assist with our vital needs.

1.2.1 Essential features

The activity must address a *vital need*. Vital needs include physical and emotional health and associated protection from factors – human and natural – that could threaten either; the freedom to pursue interests; economic stability; spiritual guidance; and education. Because humans value these so deeply, we feel particularly vulnerable when they are threatened. Hence the need for a genuine expert – a *professional*.

The members of the profession must receive *extensive education and training*. Some of the abilities necessary to be a competent professional – for example, empathetic engagement and listening skills – emerge from life experience and good parenting, but others come only through formal education and apprenticeship. Imagine, for instance, the deeply empathetic lawyer who does not know state law or who has not had training in courtroom litigation. All her care and compassion are worthless without the proper knowledge and skills and you would be foolish to place your liberty or economic security in her hands. All of the clearly identified professions, thus, require at least a baccalaureate degree and most also call for a post-graduate degree.

There must be *self-regulation* by the members of the profession, usually overseen by a professional organization, with associated credentialing. As we saw in section 1.1.3, the BMA and AMA (and, later, other groups) convinced legislators to grant them a monopoly over services by vowing to provide proper oversight of their members. Such oversight includes development of the standards that educational programs must satisfy in order to be accredited to teach professionals-in-training, determination of the knowledge and skills one must satisfy to receive credentialing or licensing, and punishment of licensed members who fall below the standards, in terms of either expertise or ethical character. Government agencies also review the associations' work, but final decisions are generally left to the professionals. For example, only other academics can determine whether someone has met the standards to be a tenured professor, only other attorneys can disbar a lawyer, and only medical societies can remove a physician's license.

In addition to the group authority and control granted by self-regulation, individual members also have considerable *autonomy* over how they practice. Although there are clear minimum standards that any professional must meet – for example, a professor must have knowledge of his subject area and a surgeon must have a good grasp of anatomy as well as the requisite physical skills; beyond that, individuals have profound flexibility over how they satisfy their client's needs. That flexibility is captured in the axiom that medicine

(or teaching, litigating, programming, and so on) is as much an art as a science. The very best professionals supplement their factual knowledge with creative insight and judgment.

1.2.2 Common features

The professional–client relationships that have, over time, emerged from these essential criteria have also produced a number of common elements, including the following:

- A *monopoly* over services. This emerges directly from the self-regulating criterion. When legislators granted individual professions the authority to determine who can and cannot practice, they also thereby granted them a monopoly over those services. How far that monopoly extends is a constantly moving target. As I write this, for example, the California legislature is debating a bill that would significantly expand nurse practitioners' scope of practice into activities currently restricted to physicians or surgeons (e.g., ordering durable medical equipment, certifying disability for purposes of unemployment insurance, and having a more direct role in the treatment plan for home health patients). Similarly, a wide range of education and training organizations have made sharp inroads into the traditional universities' monopoly over college degrees.

  Still, the monopolies are quite strong. It is against the law to give legal advice if one is not a member of the state bar; only physicians may prescribe certain medications; and one must be professionally certified to perform key engineering activities. The monopolies even extend to control over how many students are admitted into postgraduate professional programs, in part to keep supply low enough as to increase eventual practitioners' *income*.

  And because these monopolies are so strong, with little to no plausible competition, the potential for *abuse* is correspondingly high. Professional associations can establish outrageous fee structures, cover for their own when faced with accusations of incompetence

  or inappropriate behavior, and establish relationships that produce real conflicts of interest in their fulfillment of client need. We shall discuss these and related concerns in later chapters.
- The work activities are largely *mental*. While professional activities sometimes require specialized physical skills (e.g., a surgeon's dexterity and an architect's drawing talents), most professional work is intellectual – hence the need for extensive formal education. That education also typically produces a *specialized* and *technical language* that is unique to the professional activity. Such language serves both as a type of convenient shorthand among practitioners and as a way of distinguishing members. Membership in the "club" is partly determined by one's facility with the terminology.
- The intellectual emphasis also contributes to higher *social status* and, again, *increased income*. Whether or not it is justified, society values intellectual more than physical activity and compensation levels generally follow. The "vital activity" component of professional work also contributes to higher compensation, of course. The *responsibility* attached to holding someone's heart in one's hands, someone's freedom in one's arguments, or the structural integrity of a bridge in one's design warrants greater recompense.
- There is typically a strong *power asymmetry* between professional and client. This is structurally rooted in the very purpose of the relationship. The client needs help with a vital concern, help that he can get only from a professional. He is thus vulnerable and deeply dependent on the professional. He is likely also fearful, confused, and out of sorts because of the alien nature of the professional's everyday territory (one's first experience with an intensive care unit, for example, can be daunting indeed).
- The asymmetry is also created and maintained in the artifices – *the trappings of power* – built into professions and professional–client relationships. Notice, for example, the first thing that you see when you walk into a courtroom: an elevated judge's stand. The reason for that, no doubt, is partly the need for visual awareness of the courtroom, but it also serves to reinforce the judge's power (as do, of course, the "all rise" command, the black robes, and the requirement to address the judge as "your honor"). Similarly,

most of us would be uncomfortable calling our physician (or professor, for that matter) by her first name; "doctor" is more common, even while she is being far more informal with us.

These power trappings can be beneficial. A close friend once told me how reassuring it was, how it gave him a sense of confidence, when the physician treating his dying wife came into the room in a crisp white coat, with a stethoscope wrapped around his neck. However, they can also damage communication and reduce client autonomy; for example, note how frequently the professional interrupts the client and vice versa.

- Professionals generally see their work as a *calling*, as opposed to a job or even a career. Their lives are largely committed to the work and they typically *self-identify* as a professional. They recognize that they are assisting others with vital matters and see their work as providing a *service* as much as earning a living. This contributes to their willingness to fulfill special duties (see section 1.2.3), including – for the traditional professions, at least – a willingness to be *on call* twenty-four hours a day, seven days a week.

1.2.3 Role-based duties

As the preceding discussion shows, there are many privileges attached to being a professional, most notably high social status and enhanced compensation. Those privileges, combined with the core normative commitment to serve others in their vital needs, in turn produce a set of general role-based duties, as well as specific ones connected to the professional's particular role.

First among the *general* duties is the overarching commitment to have one's *clients' needs* as the highest priority. Trust is possible only if clients can be confident that their professionals are not satisfying their own interests at the cost of their clients'. It is also possible only if the professional accepts the duty to treat all his clients as persons worthy of dignity and respect. This translates into such specific role-based duties as *informed consent* requirements and respect for *confidentiality*.

Prioritizing client needs also extends to the commitment – in the right circumstances, with the right considerations at stake – to provide a professional service to those who cannot afford to pay for it. Most professional associations have a requirement of some kind of *pro bono* service. The New York State Bar, for example, recently determined that fifty hours of *pro bono* service is a prerequisite for admission to its bar, and the California Bar is considering a comparable requirement. Similarly, the service component for university tenure and promotion decisions was originally meant to capture this ethos of giving back, though these days it is largely about campus rather than community citizenship.

Another general duty is the commitment, noted earlier, to be *on-call* twenty-four hours a day, seven days a week. Most professionals now operate as part of a group, so such call requirements are managed on a rotating basis (or, in a hospital setting, by house staff). But solo practitioners still recognize that they can be called in the middle of the night to assist a client in need. Not all professional activities carry that kind of urgency but the requirement is still loosely present in *work schedules and hours*. For example, while it is rare that a college professor will need to take a 3 a.m. phone call,[4] very few work a standard forty-hour week; the work needs (class prep, grading, etc.) dictate the hours and schedule. I know of no professors who do not at least sometimes work at night and on weekends, and nearly all work at least fifty hours a week.

Sticking with the professor example: her list of specific role-based duties is too long and context dependent to list here, but includes such obligations as *remaining current* on information and techniques, *being available* to meet with students or colleagues, *respecting data privacy*, and, like health-care professionals, providing *informed consent* through a syllabus and maintaining *confidentiality*. The key point here is that the roles we adopt in life – professional, occupational, parental, friendship, and so on – all bring with them particular duties. If we fail to fulfill these roles in personal relationships, we are generally no worse than lousy friends or relatives; if we fail them in a professional context, given the vital needs at stake, we can cause profound harm.

One of the more challenging aspects of professional ethics is that role-based duties sometimes conflict – with one another (e.g., a contractual duty to one's firm conflicting with a fiduciary duty to a client)

or with one's other central values (e.g., a pharmacist's duty to dispense legally ordered prescriptions, say RU 486, with his religious beliefs regarding contraception or abortion). Chapter 2 provides a method of ethics reasoning that can help resolve such ethical conflicts and in Chapter 4 we will discuss conflicts of interest and obligation.

1.3 A Working List

Any list of the professions is bound to be contentious, so I focus here on those that clearly qualify, in alphabetical order:

architects
licensed attorneys
ordained clergy
dentists
engineers with Professional Engineer (PE) certification
physicians (including psychiatrists)
licensed pharmacists
professors
licensed psychologists
certified public accountants
veterinarians.

Each non-controversially fulfills all the essential criteria and each is deeply, if sometimes only generally, committed to the normative foundation of client trust. The democratization movement (see Epilogue) has made that commitment harder to sustain, but all these professions retain it, along with the other essential criteria.

Those that qualify as *marginal* professions fall along a continuum, with some largely satisfying the criteria but not sufficiently so, and others meeting them only in a limited way. In descending order, the following are some prominent examples:

- *System administrators*: Aspects of the computing field are in the process of formally professionalizing (Guzdial, 2013) and system administrators will certainly be among the first who qualify. They provide a vital service and are highly educated, with extensive and specialized training. For now, however, they don't have either an authoritative mechanism for certification or a sufficiently strong commitment to client well-being. There is often, in fact, no clearly identifiable client at all.
- *Scientists*: Those who are also college professors, or who have the relevant terminal degree and work for a public service agency (typically government related), satisfy all the criteria. Those who work for profit-based businesses likely meet all the technical criteria but may have just too deep a conflict of interest (see Chapter 7) to be able to fulfill the core normative criterion. Part of the difficulty here lies in determining who the client is. As with journalists and ethics consultants (Meyers, 2007), professional scientists have no distinct person as their client. Rather, the "client" of scientific activity is something like "the truth" and those whose loyalties are divided between that pursuit and the profit-making needs of the corporation cannot generate the level of trust necessary to unconditionally meet professional standards.
- *Nurses*: Their commitment certainly aligns with the normative core (client well-being as their highest priority) and most consider their work to be a calling. But their individual and group autonomy is largely constrained by the medical hierarchy, and educational levels vary significantly – ranging from associate's degree to a doctorate. *Physical therapists* and *chiropractors*, while generally highly educated and committed to the primacy of client needs, are in many ways even more constrained by medical power (depending on the laws of the state).
- *Teachers*: Much like nurses, they care deeply about their clients and they generally see their work as a calling, but they have limited power or autonomy over instructional methods and, especially, curriculum. As I write this, the "Common Core" initiative of the Obama administration grants more freedom to teachers

to motivate critical thinking skills in their students, but that freedom runs head on into the ongoing demands for high standardized test scores.

- *Journalists*: Journalists have lost much of the public trust they acquired during the Watergate era. Surveys now consistently place them among the least trustworthy of occupations. And, while they are almost wholly autonomous and highly skilled (if not technically so), journalists need not have any formal education. Nor are they subject to licensing or formal regulation beyond that given by their editors. And, as with scientists, it is not at all clear who their client is. The public? Their publisher or station owner? Other journalists? The truth?

Other fields are becoming increasingly professionalized worldwide and likely will move into the formal ranks in the coming decades, including higher ranks of military and public safety officers, other disciplines in computing (e.g., advanced programmers and hardware designers), and various occupations within the arts (e.g., museum curators and composers or conductors).

1.4 Types of Professional–Client Relationships

A last consideration is whether there is a single ideal relationship for every professional–client encounter. The short answer is no: different people – even the same people in different circumstances – have differing goals and capacities. Thus no single relationship type fits everyone. Among the more important requirements, in fact, for the ethical professional is the need to evaluate which type is appropriate in what settings and with what people. Let us consider some of the options, with their respective strengths and weaknesses.[5]

Recall that people go to a professional because they have a significant need. The professional is presumably well trained and able to provide expert advice or technical skill in relation to concerns of vital importance, including the promotion of client well-being and

autonomy. The best ways to satisfy these mutual needs can vary tremendously, with options ranging from strongly authoritative to mere agency. I list five commonly cited options here; some place greater emphasis on client well-being while others prioritize autonomy.

1.4.1 Agency

In these relationships the professional serves primarily as the client's agent, helping him to achieve his already established goals. Picture a client who routinely gets sinus infections and knows that he needs an antibiotic to clear them up. His physician serves, in these instances, as the legal facilitator for the client, since he cannot get a prescription without her help. Such relationships work well only when the client is sufficiently knowledgeable (and the professional knows this) and the professional does not object to being treated merely as an agent. Note also that it probably will not work on complex issues, wherein the very expertise that distinguishes the professional is vital to finding mutually agreeable solutions.

1.4.2 Paternalistic (or parentalistic)

The converse of the agency relationship, paternalistic or parentalistic ones put all or most decision-making authority in the hands of the professional. The client concedes authority, trusting the physician to have sufficient expertise, commitment to client well-being, and the experience and judgment to choose wisely.

Dominant prior to the democratization movement of the 1960s and 1970s, paternalistic relationships are now widely criticized in the ethics literature. Given, however, the wide power asymmetry between professional and client, along with client fear and dependency, varying degrees of paternalism are still commonly present in professional–client encounters. And they can be highly effective when client trust is present and warranted; that is, when the professional genuinely has the requisite expertise and wisdom and is truly committed to the