Professional morality is applied morality

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The problem

My assumption:

Either professional morality is grounded in morality in which case it can be claimed there is no *professional* morality. Or it is grounded in the professional practice or the nature of a profession in which case there is no professional *morality*.

Included in my assumption is that ethics and morality are being understood as equivalent as something like morality that Bernard Williams criticises, especially impartiality and universality and possibly also overridingness. Character and virtues are also fairly close to this when understood as a theory of right or good action.

Morality might provide an ultimate as non-derivative reason to answer the question "How should one live?" But if moral overridingness can be denied then morality or moral reasons may be understood as something narrower than practical reason as normativity more generally about how to live, especially about what to do. It might be one part of a dualism of practical reason with prudence being the other and where judgement will be required for action. Or perhaps there is a plurality of practical reasons with moral reasons and prudential reasons being but two each with their own normative dimension and no overall normative ought and again judgment will be required for action.

But on any account it is puzzling how to understand *professional morality*.

Each of us are subject to the same moral requirements. Even if it is claimed there are different moralities for different societies it is a bit of a stretch to say there is also a distinct *morality* for professions or each profession or even parts of each profession say a nurse specialising in elderly care and a nurse specialising in Public Health and each perhaps within a particular society and at a particular time.

Morality must be practice independent ethics need not. The distinction between ethics and morality is important in what follows about professional morality where part of the problem is, I think, that sometimes morality is being conflated with professional obligations based on professional norms so that as Bem-Moshe (2019) states what is known in the literature as an internal morality of medicine should be the internal ethics of medicine. Assuming there is such a thing as professional norms in the strong sense of providing reasons that connect with rationality or importance an internal ethics of medicine will still be subject to the question of "How should one live?" and especially "What should one do?".

For three reasons, virtue ethics is included under my assumption and it is often thought to be more like ethics broadly conceived than morality. First, it is hard to distinguish virtue ethics *as a theory of right action* from non-principle-based deontology which makes no specific reference to virtue in their accounts of right making properties (Crisp 2015). It might be that there is non-instrumental value to virtue or to having virtuous dispositions, though not mere dispositions, but I doubt that this should affect reasons for action. Second is the need for an idea or 'blue-print' of flourishing and thus it seems unlikely that there can be a professional idea of flourishing. It is too specific or narrow as an account of flourishing being

based on human biological function but not rationality or something similar including the rational ability to recognise human and theological goods and avoid damaging such goods. Third, I think the ultimate question being addressed by professionals is what should be done whether this is what ethically should be done or morally should be done (Iltis and Sheehan, 2016).

However, as far as I can tell there is no one is claiming professionals have a distinct virtue *ethics* where a vice becomes a virtue unlike claims for a distinct morality for professionals, though some have claimed that vices in professionals should not in some sense be condemned under a virtue ethics account which I think comes fairly close. But there remains problems nevertheless for understanding within the sphere of the virtue the right mean and also understanding the broader notion of flourishing in relation to a profession and all within a value or morally pluralistic society.

Bernard Williams (1995) writes about a professional morality and its dispositions and how such dispositions can diverge from (I think) morality but I am unsure what the dispositions are diverging from in Williams' paper. I think it must be something more than dispositions of others who are not professionals. He was writing for a book about American lawyers and the dispositions were something to be frowned upon by non-lawyers as well as the person themselves when discounting their role as a lawyer. But I find this hard to understand if the dispositions are needed to promote the system of justice and people agree it is not morally wrong to do as they dictate then in what sense is having such dispositions a divergence. Also, as virtue dispositions as opposed to mere dispositions, they must be getting things right and so how can it divergence?

Presumably it is ethics which takes into non instrumental account of virtue as a form of praise. In this case virtue dispositions as opposed to mere dispositions are recognised as *normatively valuable* enabling one to judge rightly or as one ought as to what to do at the right time and place etc. (Crisp, 2015). Where such praise is distinct from praising someone for their right action. Whereas morality is about right action.

So, if what is meant in the literature by professional morality or professional ethics is at best professional norms then I think there is no problem as to how it might diverge from or be distinct from morality understood as impartial reasons or at least it is a different problem especially when it comes to how to understand such norms including dispositions in actual practice.

Relatedly and perhaps especially important for nursing, a point of a professional morality is one of setting moral boundaries but which I think is conflated with the setting professional boundaries as to what the particular profession should do understood as acts that are constitutive of what it is to be that type of professional usually some account of healing or pathocentric health (McAndrew, 2019) for medicine, with nursing having a much more generic and thus problematic end for any internal morality. But as Nozick (1974) pointed out in a foot note some time ago why not have 'Schmocters or Schmurses' which are people who do everything a doctor or a nurse does except more. This is why Pellegrino (and I think MacIntyre) ultimately resort to a practice independent, Natural Law account of morality, worried that doctors will become what they call 'mere' technicians some of whose actions will be bad and wrong *even if* the profession perhaps with others *agreed* they could be right

and good or if it is different even if it is constitutive of the profession to only do certain acts and avoid others.

One solution may be to understand moral norms and professional norms as domains within practical reason where the ultimate question is "How should I live?" And that moral reasons are not overriding perhaps to the extent that non moral reasons have such a force that it results in the loss of rational permission to conform to a moral norm (Dorsey 2016) or perhaps even if moral reasons are overriding that non moral reasons can prevent a moral reason being a moral requirement (Portmore, 2011).

This may be on the right lines as an answer as to how there could be a distinct professional ethics understood as professional norms or standpoint rather than morality. And I think it might indeed be on the right lines if the reasons are about well-being.

Professional morality: distinctness and divergence

Much of the literature is fairly clear that a professional morality is not greater specification or application of a moral principle(s) to situations involving a professional. But a stand-alone normative as opposed to descriptive *professional* morality seems almost conceptually mistaken even as a form of moral relativism. A further problem raised by Bernard Williams is that as a *professional* morality it implies the agent who is a professional may have another morality that may not be able to be held consistently by the agent.

There seem to be two general accounts of how there can be a professional morality that diverges from or is distinct from morality

1. Special obligations of *roles*
2. The nature of (some?) *professions*
    a. MacIntyrean practice: social construction of such good(s)
    b. "MacIntyrean practice": realist as goods independent of any construction

Examples aiming to show how immoral actions can become moral for professionals seem dubious in their moral claims or equivocate between morally permissible and non-morally especially perhaps legally permissible. It is rare to find authors explicitly arguing for a professional morality to be *distinct* from morality, usually the claim is that professional morality diverges from ordinary morality. But it is hard to make sense of divergence that is not also distinctness.

Here are three examples discussing professional morality that are not ultimately distinct from morality. Example 1 is based on the idea of special obligations of a role (profession) being a contract, promise or agreement. Example 2 is based on the idea of medicine as a MacIntyrean socially constructed practice and example 3 is partly based on 2 but denies the social construction of the practice. As we shall see some claim that being a professional means at least sometimes doing what is in some sense morally forbidden (Rhodes, 2019; Freedman, 1978).

1. Promissory / contract model as an agreement to special standards. Here moral permission becomes moral obligation for professionals. But unlike a contract one cannot bind oneself to the promise to do evil (Eriksen, 2016).

2. Divergence is justified by morality but a contextualist and particularist approach to morality is required. Professional ethics is an independent part of morality though not deducible from universal principles it must cohere with morality. The divergence is from the distinctive features of the professional practice. [Goods internal to a practice is the example given] (Baron, 1999).

3. This morality is internal since it is derived from the nature of medicine itself and not from the application of pre-existing moral systems to medicine… The moral authority of an internal morality of medicine is independent of whether or not physicians accept or reject it. Adoption of the precepts of an internal morality in a professional code or oath is not a warrant for its moral authority. That authority arises from an objective order of morality that transcends the self-defined goals of a profession (Pellegrino, 2006).

1 Is along the lines of the *creation* of moral reasons by promise / contract/ agreement. except that it is an agreement by professionals to do more than what may be permissible or required according to moral theory. Whatever the limits might be for professionals to do it is also restricted morally such that a professional must not do 'evil' or morally forbidden acts.

2 Is explicit in its claim that there can be divergence though such divergence is justified by morality. Its foil is I think a little bit of a straw man when it claims 'Moral Theory' to be able to be used to deduce from moral principles and rules specific moral judgments criticising in particular morality as both universal and impartial and also codifiable system. It follows in part Williams' critique of the morality system and recommends instead a more Neo-Aristotelian focus on goods and virtues and especially the MacIntyrean idea of a practice and social construction. However, it is unclear as to how such a morality can be both independent from and also cohere with morality.

Additionally, Baron claims there is a type of reason which should be counted as moral that is not derived from an impartial perspective (xxix). Such reasons are not personal because of the (socially constructed) nature of the professional role but neither are they impartial (impersonal) because the nurse himself is motivated by them. "Identifying them as her reason to act". I think Baron is assuming reasons internalism. Impartial reasons are one thing whether a nurse or anyone else is motivated by them another.

3 The third account of how there might be professional morality is different in its approach though uses an adaption of MacIntyre's notion of a practice. This is also emphasised in accounts of virtue ethics for professionals (Oakley and Cocking, 2001; Pellegrino, 2006). It is an adaptation of MacIntyre's notion in that Pellegrino is wary of any sort of social construction of the goods of medicine hence his account of a realist moral theory. This seems to make the point of an internal morality redundant.

A major part of the point of the professional morality was to set moral limits on what it is doctors should do and that can be useful in today's multi-cultural value pluralist world. But Pellegrino's own account of Natural Law results in an inconsistency in this claim (Kopelman, 2019). Other perhaps less absolutist accounts of morality still need to show in what sense the necessity of a theory or account of flourishing or whatever leaves room for any notion of a distinct or divergent virtue or morality for professionals.

Professional morality as a distinct morality

Rhodes (2019) claims that the main reason for or the first professional duty of professional morality is to maintain trust in the profession and for healthcare professionals to be trustworthy. This seems to me like an important but contingent reason for a professional morality. But also, how it can do so when it claims a distinct morality is unclear for example how will it fare any better in a morally pluralistic society than morality?

What I want to focus on now is the claim that a professional morality is distinct from morality. Rhodes (2019) makes it explicit that professional morality is distinct from ordinary morality. "I make a case for regarding the ethics of medicine as distinct and different from common morality" (Rhodes, 2019, 770). And that everyday ethics and medical ethics are incompatible (ibid).

Importantly Rhodes explicitly claims permissible behaviour is impermissible and impermissible behaviour is a duty. If by this, it is meant morally impermissible behaviour becomes morally permissible and morally impermissible behaviour becomes a moral duty then I am stuck as to how morality is being understood. I don't think it is meant as a type of moral relativism.

How can being in a role or perhaps differently being a professional (see Rhodes, 2019) make such a moral difference such that a morally forbidden act becomes at least morally permissible. And how does the person who is a professional as well as many other roles keep this distinction in one head when he asks himself "How should I live?"

Interestingly Rhodes claims Pellegrino and Thomasma (1981) to be allies in the idea of a distinct morality for professions, but on my reading of their work they do not claim this but fall roughly into all three accounts above and like MacIntyre (1999) ultimately ground the practice in natural law with a mono-theistic ground. So, what is evil (impermissible) remains so for anyone in a role or a profession or otherwise. Rhodes herself claims her account is a type of internal morality. However, it is not to be equated with role morality for which Rhodes claims *is* a part of ordinary morality. Rather being a professional is a morally relevant distinction such that there is a distinct morality where a usually forbidden act becomes at least permissible perhaps even obligatory.

Rhodes (2019) gives examples to illustrate why a distinct morality is claimed to be necessary for professional ethics. Such reasons have been debated for many years and I do not think I can add anything new to them except to say as a nurse (and having studied a bit of philosophy and bioethics) I find the moral claims mistaken especially in the sense of what is morally expected or conflated with non-moral norms such as the law.

> A nurse siting in the A&E or a busy ward reading and drinking coffee would not be doing the right thing. The contrast is anyone who is a not a nurse (or healthcare professional). Rhode's claims that this is because medical professionals have a positive duty to respond to patient needs and to actively promote their health.

Assuming the nurse is not on a break or sitting for some other good reason then he ought at least legally (if he is employed by the hospital) be helping and there is a professional norm also to help. Assuming the department needs help it also seems plausible that morally he should also be helping because he can and at no significant cost to himself. It is somewhat open as to how much is expected of one by morality. But this applies to anyone where some

good can be done. However, it is likely that a person with no nursing skills at all may be more of a risk than a help if she tried to do the same acts as a nurse, but help can be given in different ways.

> We are free to impart what we learn, and exceptions typically require explicit requests for keeping divulged information secret (e.g., promises and non-disclosure agreements) or a special understanding arising from an intimate relationship. In medicine, at least since the time of Hippocrates, confidentiality is presumed, although some exceptions can be justified.

For Rhodes (2019) some exceptions are justified so this is not an absolute claim. Perhaps it is one of stringency of reasons or weight of reasons. However, is it really true that we are free to impart everything we learn about others. Is not confidentiality assumed in most relationships at least morally assumed. Someone who did not know about the practice of healthcare especially perhaps in institutions with multi-disciplinary teams who are often strangers might want a doctor's or nurse's explicit promise. Indeed, when patients and people have something important to tell they often do ask for a promise. I found this frequently when nursing people with AIDs in the 1980s.

> In social situations, asking probing personal questions is regarded as rude. We should not inquire about the details of other people's sex lives, their constipation, their drug use, or even their weight. Yet, taking a complete and detailed patient history can include asking about a patient's diet, bowel habits, sexual practices, drug use, previous illnesses, emotions, and fears.

Again, this depends on who the 'we' are and in what social relations and what the actual circumstances are, all of which can be encompassed by morality. But the point of giving these three examples is the use Rhodes makes of them.

The moral distinctions being:

> A **moral ideal** is transformed into **a duty**. The counterexample is that non-medical professionals can look after their own interests but medical professionals must act for the good of patients and society.
>
> **Permissible** behaviour is **impermissible**. The counterexample is share information but the duty of medical ethics is confidentiality.
>
> **Impermissible** behaviour is **a duty**. Counter example is minding your own business but the duty of medical professionals is to probe.

Presumably the distinctions are prefixed by morally. And the puzzle, for me at least, is to understand the sense of moral in use. It is worth running through briefly a few of the reasons Rhodes gives for a distinct professional morality. Each point I think has been covered within the literature on professional ethics/morality but it will help to get a feel I think for my puzzlement (or confusion) and perhaps someone today can provide the solution.

According to Rhodes the need for a distinct professional morality is due to:

Different expectations

> This graphic depiction of the difference between the duties of medical ethics and common morality highlights our different expectations for the behaviour of medical professionals and non-physicians. If common morality and medical ethics were the same, then the ethically justified behaviour for medical professionals and everyone else would be the same. However, in the absence of a robust explanation of how the same premises lead to contradictory conclusions for medical professionals and others we should recognise that common morality is not consistent with medical ethics.

Rhodes holds that the acts performed by medical professionals (read healthcare professionals) in a professional context make for significant differences that make a moral difference. I think Bernard Williams (1995) gives short thrift to this re act descriptions such that some acts would be immoral if done by those not in a professional role. The fact that others cannot do the same act not just in professional roles but any role or special, specified circumstance. And thus, I think, expectations will also vary. Rhodes agrees (774). Yet Rhodes claims that unless there are distinct moralities, we end up in confusion because of this. However, day after day nurses and doctors carry out their work and there seems little confusion, because there are good reasons for such actions and for much of the time are encompassed by morality.

Expectations might vary as practical reasons, but will moral expectations vary such that the profession itself makes morally forbidden acts a moral duty? Again, Bernard Williams' (1995) has an insightful point that this in a profession would be unlikely, and that the profession would not survive long if such a situation were to be the case. At a general level there will I think be the usual expectations of competence, due care as well as not morally bad. Additionally, unless an absolutist stance is held it is hard to know which acts would be morally forbidden and if an act were morally forbidden how being a professional could alter the valence to one of a 'duty'.

Finally, much depends on whether it is true that moral principles lead to contradictory actions. To do so needs the one standpoint but Rhodes states that it is contradictory for healthcare professionals and others. Where this will matter is if there is a distinct professional morality and another morality such that one nurse must (it seems) both do and not do an action.

Action guidingness

> The resulting 'untidiness, complexity, and conflict'[of Beauchamp and Childress' principals' approach] may be tolerable or even advantageous in public debates and academic ivory towers, however, patients need to know the parameters of what is reasonable to expect from physicians and medical professionals need at least clear signposts for navigating the complicated terrain of clinical practice.

Ethically justified actions of professionals and non-professionals could be the same but whether it could extend to morally impermissible (forbidden) becoming morally permissible needs further explanation of what morality is taken to be and seems intuitively doubtful to me. Rhodes is explicitly claiming that a principles approach and the common morality of

Gert are not sufficient for medical ethics. Perhaps other normative moral theories could be. Rhodes (2020) herself holds to a contractarian constructivist theoretical account.

This point also shifts the ground somewhat from a distinct ethics to the idea of clear action guidance / parameters on action for healthcare professionals which must be clear to both the professional and the patient. It is plausible that moral theorists do not think of morality in this way. Much hangs on how specific such clear parameters are required and the extent this is plausible (or necessary) in practical concerns especially perhaps ethics but even something as heavily codifiable as what action to take to provide basic life support/resuscitation. In any case professional morality is not without the same problem.

The nature of a professional

> Role morality is consistent with common morality, and special role-related obligations (e.g., being a parent, butcher, baker or candlestick maker) derive from individuals' voluntarily assuming special responsibilities by making an explicit or implicit promise. The starting point for recognising that medicine requires its own distinctive morality lies in appreciating that medicine is not a role but a profession and what that means…The critical point that has not been adequately appreciated is that the concept of medical professionalism is derived from the distinctive ethics of medicine.

Rhodes (like Pellegrino and Thomasma) distinguishes roles from professions and moralises the idea of a profession. But it is not moralised by applying ethics to a profession but by an already distinct professional ethics. For Pellegrino this is a realist objective ethic of Natural Law. Rhodes (I think) holds a contractarian constructivist account of morality and presumably this would allow a distinct morality for professionals. But two particular problems seem to me pertinent here. One is that the (morally) normative account of a profession needs be assumed otherwise it is hard to know how agreement even if by reasonable or rational beings could be sufficient for the sort of norm we are interested in as morality. The second point is that it seems that a theory encompasses the norms of a profession and so the norms cannot diverge or be distinct.

It is worth noting that under the term ethics of medicine Rhodes includes all medical specialities and all healthcare professionals including nurses, chaplains and bioethicists. And that the differences become so for just *healthcare* professionals. It is not clear if all of the classical professions are to be included or just healthcare professionals. Further any notion of a distinct professional standpoint would be hard to maintain, rather it would be a healthcare professional standpoint. Yet there are distinct healthcare professions and under most accounts of what a profession is includes a distinct body of knowledge and thus standpoint. There looms a problem of where to draw the boundary. The provision of vital goods are provided by distinct professions and has been argued not just professions but also MacIntyrean practices and even beyond to other roles. An implication being that they too require distinct ethics.

Internal morality because only the profession knows what counts as good within its practice

> Medical professionals are the ones who define professional duties because they are the only ones who adequately understand what is involved, appreciate potential risks and benefits of their services, and distinguish competent practice from unacceptable performance. Therefore, the ethics of medicine is internal to the profession: it is constructed by the profession and for the profession, and needs to be continually critiqued, revised and reaffirmed by the profession.

I think this is very problematic and has been subject to acute criticism by Robert Veatch (2001) in relation to Pellegrino's and Thomasma's (1981; 2001) similar idea. It is very problematic when it claims professionals are the ones who understand the risks and benefits and competent practice from incompetent, implying others do not. Healthcare is inherently evaluative. One extreme account of this idea claims

> We believe that the profession of medicine can and should claim certain broad values that cannot be superceded by individual values…if the value is shared by overwhelmingly by the profession, though not necessarily universally, then the value is a professional one that should not yield to individual preferences (Volandes and Abbo, 2006).

Apart from the slide from values of the profession of medicine to preferences of others it raises a question as the scope of this professional good. Would all physicians hold to the same values when the values themselves are probably a part of a wider system. Volandes and Abbo rely on a constructivist account of getting agreement on values by most physicians in a particular place and time. The conclusion about ethics does not follow from such premises about professional duty especially where duty is defined by the professionals. And the notion of morality as socially or even professionally constructed is itself contested as both Pellegrino (2005) and MacIntyre (1999) recognised and ultimately rejected yet Rhodes holds a contractarian constructivist account of morality.

Finally, it is relevant to the idea of a so called nursing ethics to take something from Bernard Williams again about professional morality and its dispositions for two reasons. The first is I do not understand how, despite Williams' claim that they do, they are meant to show divergence from morality. And the second is that the expectations of non-professionals and perhaps professional bodies themselves about these dispositions is to respect such dispositions. Williams was writing about American Lawyers though I assume the paper is applicable to all professionals. The issue of divergence seems to be that although such dispositions can be justified by second order arguments justifying the profession's existence (perhaps something akin to Rawls' two concepts of rules) this is too abstract a level. The professionals themselves are the ones who must have and live with such dispositions. But such dispositions are justified morally so I wonder in what sense they diverge.

The second point is that Williams rightly claims that if too much is asked of the sentiments they can break down or fall back on mystification. Reliance on the idea of the dignity of a profession can become a myth. Perhaps the dispositions of American lawyers are ones that may sometimes be poorly thought of but necessary to have as a lawyer. For nurses I think it is the opposite. Nurses are expected to have in some sense altruistic dispositions and yet

justification especially in the idea of the nurse as a professional because of this has I think become a myth. I do not think virtue ethics could justify the image expected of nurses' character and behaviour this is in part because it does not get the balance of virtue dispositions right. Unlike Williams' example of lawyers and the risk of them as individuals becoming people they and others regard morally poorly nurses seem to struggle to become people that other people and their profession think they morally ought to be in a very strong altruistic sense of morality. Perhaps professionals need the virtue of integrity which requires reasoning as 'ethical accuracy' (Webber, 2022) similar to *phronesis* but perhaps more realistic as developmental neither natural virtue with its somewhat nebulous or unclear specifics nor perfectionist ideals (ibid.).

An answer

A potential answer to the problem of a distinct professional morality understood as professional ethics about how should one live, is to deny moral requirements indeed any requirement has ultimate normative authority. Rather moral reasons as moral norms have moral authority, professional reasons as professional norms have professional authority etc. But on such an account it is hard to see why some things matter more than others perhaps like reasons for counting blades of grass.

A suggestion following Dale Dorsey (2016) is that although moral rationalism is denied morality matters, there is almost always practical reason to do what is morally permissible, there is an over-arching normative or rational standpoint and one can sometimes be rationally justified to behave in an immoral way. Though practical reason generally allows at least permission to follow moral obligations sometimes it does not where non-moral reasons can take priority to such a degree that moral behaviour can become *normatively* impermissible. Perhaps one has internalised the value of being a nurse to such an extent that some non-moral action that is a part of what it means to be a nurse results in the loss of rational permission to conform to a moral norm (Dorsey, 2016).

If morality does provide ultimate impartial reasons for what one should do then there cannot be a distinct professional ethics that allows morally forbidden acts to become morally permissible. If morality does not provide ultimate and impartial reasons then there looms the problem raised by Dorsey (2016) for his own strong anti-rationalist account (as well I think for Baron's account) that when one's central life's interests or projects are at stake they can override any moral concerns in such circumstances. This is meant to be more than the point that prudential reasons matter and can in some sense compete with moral reasons, here moral reason still retain their force though prudential reasons can override it. Rather it is that one's central life projects and the values involved are likely to be influenced by one's upbringing, including an upbringing of privilege, and thus prudence might justify immoral action for the rich.

Another account that accepts moral rationalism, also claims all reasons need not be morally relevant reasons as reasons that contribute to moral status such that some reasons can justify acts it would otherwise be morally impermissible to perform and that they do not count morally speaking (Portmore, 2011). In this case it has to do with giving moral reasons their appropriate weight. If one is led by sound practical reasoning to a non-moral action then one ought not be blamed. So, where there is no decisive reason of a moral nature and

decisive reason of a non-moral nature after sound deliberation the latter will be what ought to be done. But it is not action that is *morally inappropriate* because the weight of moral reasons is not such to be decisive.

However, whatever side of the rationalist anti-rationalist debate is most plausible I think neither provides support for a professional *ethics* where this is equated with morality. It is hard to maintain that what is morally forbidden can become morally permissible or that any justification is needed for the divergence as there would be if it were professional norms rather than morality in question.

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