In Defense of Bioethics

Robert Baker

Medical ethics consultation is and can only be what it purports not to be — a moral, if not an ethics, disaster. It has acted unprofessionally, because ... of its failure to do what a profession worthy of the name would do: formally accredit the programs that educate and train its practitioners, formally certify and license its practitioners, and formally establish a meaningful, binding, and enforceable code of professional misconduct. .... If the field truly took itself seriously, what it means to seriously be a professional and to behave professionally, and what it means to be honestly concerned with the public interest, not only would it bring itself and its members under the rule of law, it would have done that a decade ago.

Giles Scofield

Reading Scofield’s scathing indictment of my field, bioethics, reminded me of how it felt, as an American liberal committed to the cause of racial justice, to read Soviet diatribes against American racism published during the Cold War. I shared with the authors a deep commitment to rectify the injustices they protested. Yet, like Scofield, they proffered accounts of events so radically selective and decontextualized that their version of history seemed more akin to fiction than to fact.

Scofield’s Indictment of Bioethics

The gist of Scofield’s indictment is captured in the passage selected as a prefatory quotation. “Medical ethics consultation” is indicted as “an ethics, disaster” because a report that the ASBH issued a decade ago, in 1998, did not recommend what Scofield believes that any profession worthy of the name should have recommended: to “formally accredit the programs that educate... practitioners, formally certify and license its practitioners, and formally establish a meaningful, binding, and enforceable code of professional misconduct.” Scofield avers, moreover, that since the field did not “bring itself and its members under the rule of law...a decade ago,” there is no reason to credit current efforts to develop a code of ethics for clinical ethicists.

Why does Scofield believe that this decade-old report so impugns the integrity of the ASBH that its
current efforts at professionalization are suspect? This report, *Core Competencies for Health Care Ethics Consultation*, was drafted by a task force of 21 leading clinical ethicists at the behest of two of the three societies that combined to form ASBH, the Society for Health and Human Values (SHHV), and the Society for Bioethics Consultation (SBC). As Scofield tells the tale, these societies created a task force whose mission was to look into [but that] ...decided against professionalization, i.e., against certifying those who provide ethics consultation, against accrediting programs that train them, and against adopting a code of ethics to govern them. Instead, the task force decided to adopt precatory, as opposed to mandatory standards: the so-called “core competencies.”

Ostensibly this did not mean that ...concerns [about lack of professionalism] were misplaced, but only that they were — for some reason or other — ill timed.⁵

Scofield avers, however, that the real reason the report recommended against immediate professionalization was that the task force believed that “certification...would run into the problem of the impossibility (for political reasons) of being able to exclude any of the ‘grandfathers of bioethics’ including ‘charlatan grandfathers.’”⁶

Having indicted bioethics past as self-serving, Scofield tars present efforts at professionalization with the same brush.

_Now_ the chickens finally are coming home to roost [and] “less-than-qualified” individuals are doing “less-than-adequate” jobs.⁷

...whereas it once served the field’s self-interest for its boundaries to be porous, nebulous ... it now serves the field’s self-interest for those same boundaries to be closed, defined, and well defended. ... Why? For reasons having to do with such matters as ...“identifying and managing improper pressures and boundary violations by employers and supervisors.” Why do ethicists need a code of ethics? To protect themselves from the boundary violations others commit, not others from the boundary violations they commit.⁸

Concluding that the field is hopeless—serving and indifferent to the public interest, Scofield ends his indictment with the section containing the quotation prefacing this paper. The paragraph ends by calling for external regulation of the field: “That ethics is too important to be left to the ethicists is, if not self-evident in and of itself, amply demonstrated by the cavalier manner in which the field has conducted itself.”⁹

**Professionalization: Comparing Law, Medicine, and Bioethics**

To put the ASBH’s effort at professionalization into perspective, it is helpful to compare it to the professionalization process in such paradigmatic professions as medicine and law. Fields typically evolve through three stages if they are to become professions in the classical sense, i.e., self-regulating occupations whose members undergo specialized training and education and who are publicly committed to, and accountable for, serving some public good. The first stage is _traditionalism_. At this stage, occupational conduct is regulated by traditions of practice: the field lacks authoritative formal rules, practices, training procedures, or mission statements. As they professionalize, traditionalist occupations enter a second stage, _formalization_: amalgamating received traditions and practices into formal documents, like codes of ethics — attempting in the process to rationalize and justify, not only traditions and practices, but the field more generally. Ideals of service to some public good are typically evoked, and advisory — or, precatory, to use Scofield’s legalistic turn of phrase — codes and educational standards are advanced. In stage three, a field fully _professionalizes_ by asserting self-regulatory authority over its membership and educational institutions, and by providing authoritative statements of its mission or ideals to its membership and to the public. Training and education are held to formal standards and are recognized by accreditation, certificates, and/or diplomas. Formal codes of ethics of ethics are adopted, and organizations invest their authority in their promulgation, interpretation, adjudication, and revision, and also in some measure of direct or indirect enforcement. As educational standards and ethical codes become accepted as authoritative within the field, by the public and, perhaps, by legal authorities, the field begins to characterize itself, and is recognized by others, as a “profession.”

Scofield has indicted the ASBH because, in the year in which it was founded, 1998, it did _not_ immediately endorse full professionalization. How reasonable is this demand? Like most national occupational societies, the ASBH was built on the foundation of earlier societies: SHHV (founded in 1968 as an organization of educators and medical humanists employed in medical schools); SBC (founded in 1985 as a society of clinical ethics consultants); and the American Association of Bioethicists (AAB, founded in 1994 by
bioethicists engaged in bioethics education, research and scholarship, many of whom were not members of SHHV or SBC). As Scofield observes, since none of the precursor organizations had been committed to professionalization, some task force members believed that insistence on full professionalization would be “ill timed.”

Is there precedent for a national society insisting on immediate professionalization during its founding year? If so, would ASBH members be familiar with such a precedent? ASBH members are most likely to be familiar with the history of such national professional societies as the American Medical Association (AMA), which was founded in New York City and Philadelphia in 1846 and 1847, and the American Bar Association (ABA) founded in Saratoga Springs, New York, in 1878.

The ABA took two decades to adopt its first code of ethics (1908). Scofield’s indictment of ASBH is thus not supported by the history of professionalization of the ABA. The history of professionalization in the AMA, however, seems to offer more support. To simplify and condense a complex tale: U.S. municipal, county, and state medical societies date to 1766. In the early 19th century governmental bodies began to recognize as authoritative the apprenticeship standards of regional medical societies. These societies, in turn, encouraged governmental recognition of their authority by adopting formal codes of ethics. By mid-19th century, however, a spirit of Jacksonian democracy led almost all states to repeal medical societies’ de facto “licensing” authority as “elitist” and “anti-democratic.” Consequently de facto licensing authority devolved from the medical societies to the medical schools, and a doctorate issued by any medical school effectively became a “license” to practice medicine. As there were no standards for accrediting medical colleges, however, “[T]he college that offered to confer [a medical degree] after attendance on the shortest annual courses of instruction and the lowest college fees could generally draw the largest class.”

Alarmed by these medical diploma mills, a 30-year-old New York physician, Nathan Smith Davis (1817-1904), persuaded the Medical Society of New York to convene a conference on standards for medical education. The conference, which met in New York City in 1846, was unable to resolve the issue of standards for medical education, so it convened a successor conference in 1847 to found a national medical society dedicated, among other things, to reforming medical education and developing a code of medical ethics. It would be well into the next century, however, before the AMA would establish authoritative standards for medical education. Thus, although the AMA embraced the ideal of accrediting medical schools in 1847, it did not begin to achieve this ideal after 1910, some 63 years after the AMA’s initial formation. If one assesses the progress of the 10-year-old ASBH by this standard, unless the pace of professionalizing educational standards for clinical ethics is delayed by over half a century, comparison with the AMA offers scant justification for Scofield’s scathing indictment of the ASBH.

Scofield’s indictment, however, focuses more on codes of ethics than on educational standards. Here the history of code development in the AMA seems to offer better support since the AMA proclaimed its code of ethics immediately upon its founding in 1847.

Scofield affects what I characterize as an impatiently perfectionist standard to measure progress towards professionalization, blinding himself and his readers to the significant progress the ASBH has already made in professionalizing bioethics.

Why, Scofield might insist, could the ASBH not follow the AMA’s precedent by proclaiming a code of ethics at its first meeting? Why could the ASBH not have made mandatory the code of ethics for ethics consultants recommended in the Core Competencies report?

A closer look at the history of the AMA’s code of ethics provides an answer. As the committee drafting the AMA code of ethics announced to the 1847 conference, it could recommend instant adoption of a code of ethics because the AMA’s constituent state and local medical societies had already adopted codes of ethics “based on that by Dr. Percival [1803] … and the phrases of this writer were preserved, to a considerable extent, in all of them.” Drawing on the apparent consensus emerging from a half-century of code creation, the committee was able to adopt a code immediately. (The ABA, also heir to decades of earlier codes, however, took two decades to develop a code of ethics.) When the ASBH was founded in 1998, in contrast, it was not heir to decades of precursor codes. To reiterate: in 1998 there were no precursor codes of ethics for bioethicists or clinical ethicists — indeed the
ASBH was in the process of publishing the very first proposal for a code of ethics for clinical ethicists. In this context it would have been foolhardy for ASBH to insist upon a mandatory code of ethics. The point of rehearsing this history is to put into perspective Scofield’s scathing indictment of ASBH for failure to immediately embrace full professionalization — accreditation of educational programs, certification of clinical ethics consultants, and a code of ethics — in the very year of its founding, or even in its first decade of its existence. Scofield’s soaring rhetoric of outrage, the litany of imprecations, and charges against the integrity of the field rests on the ASBH’s failure to achieve, either in the year of its founding or in the brief decade of its existence, what neither the ABA nor the AMA were to achieve in the year of their founding, or over the course of decades or even the better part of a century. It is an unreasonable expectation. As Voltaire famously declared, le mieux est l’ennemi du bien, the perfect is the enemy of the good. At any point between 1847 and 1909 a Scofiedian perfectionist could have indicted the AMA as a disaster “because ... of its failure to do what a profession worthy of the name would do: formally accredit the programs that educate and train its practitioners, formally certify and license its practitioners.” Full professionalization has never been instantly attainable by any field and while the ASBH’s efforts at professionalization are open to criticism, its inability to instantly professionalize is not the standard by which it should be judged.

The ASBH’s 1998 Core Competencies Report
Scofield’s impatient perfectionism also blinds him to the significance of the Core Competencies report. As noted above, the report was commissioned not by the ASBH but by two of its precursor societies, SBC and SHHV. The goal of the taskforce was not to “professionalize” ethics consultation, as Scofield reports, but more modestly to assess the nature and goals of clinical ethics consultation, to identify the skills, knowledge and character traits (i.e., the core competencies) essential to ethics consultation, to discuss evaluating ethics consultation, and to formulate the obligations of ethics consultants and the institutions that employ them.

In 1996-1998 these were not modest goals. Consequently, the Core Competencies report is a compendium of authoritative firsts: the first consensus statement on the nature and goals of clinical ethics consultation; the first consensus statement on the core competencies — the knowledge, skills, and character traits — required of ethics consultants; the first consensus statement on the need to evaluate ethics consultants and the ethics consultation process; and the first code of ethics for ethics consultants. By any reasonable standard Core Competencies is a watershed in the development of clinical ethics consultation as a field. The ASBH’s endorsement of the Core Competencies report at the very moment of its formation is thus a milestone on the road to professionalization. Only an impatient perfectionist could fail to appreciate its significance.

Scofield proclaims either his impatience or his unfamiliarity with the process of professionalization in the “What’s My Line” section of his paper. Here he critiques definitions of “clinical ethics consultation” as ambiguous and circular. To put this critique into historical perspective, consider the difficulties that the AMA had in its founding year, 1847, in describing who would qualify as a physician. “Regular physicians” are characterized as those received a “regular medical education” based “on the accumulated experience of the profession” (AMA 1847, Chap. II ART. IV sec. I). A regular physician is thus someone who received a regular medical education, i.e., an education provided by regular physicians. The recursive nature of this characterization, its apparent circularity, is a function of the absence of professional standards at the point of transition between apprentice-based standards of conduct grounded in “the done thing” and formally articulated standards of achievement. In the absence of any formal standards for stipulating who counts as a physician in 1847 — or who counts as a clinical ethicist in 1998, or in 2008 — definitions naturally appear fuzzy, recursive, and circular.

Stage two of professionalization is an existential quest in which occupations strive for self-definition, attempting to delineate themselves — who they are — to themselves and to others. Only after a field enters stage three, professionalization, can legitimate practitioners be readily designated: for at that point practitioners have been formally credentialed so that they can be defined in terms of their certificates, degrees, and licenses. Nineteenth-century Scofiedian perfectionists could have skewered the AMA’s recursive characterization of a regular physician as one who was regularly educated by regular practitioners as so blatantly circular that the AMA would have never developed meaningful standards. History would prove them wrong.

Scofield’s fulminations against the Core Competencies report also distracts attention from one of the taskforce’s major achievements: drafting the first code of ethics for ethics consultants. Concerned about “the dangers of abuse of power and conflicts of interest” on the part of “those who do ethics consultation,” and desiring to articulate “institutional obligations
to support those who offer ethics consultation services,” the task force developed a short code of ethics that is reproduced below. The literal meaning of the Latin expression *res ipsa loquitur* is that “the thing itself speaks.” In the case in point, the code of ethics published in the *Core Competencies* itself speaks eloquently to rebut Scofield’s charge that the task force was not concerned for the interests of patients or the public. This section of the *Core Competencies* report is quoted in full.

§ 5.1 *Abuse of Power and Conflict of Interest*
By virtue of their role in health care institutions, ethics consultants are both granted and claim social authority to influence:

- The clinical care of patients
- The behavior of health care providers toward families of patients and toward each other
- The behavior of health care institutions toward patients, families, health care providers and the larger community.

It is therefore inevitable that ethics consultants hold a certain degree of power that, under certain circumstances, can be abused. The potential for abuse of power is not unique to ethics consultants, but instead, a problem for all health care providers. It is inherent in their role and specialized knowledge, as well as the vulnerability of the persons they serve. The potential imbalance of power imposes a special obligation on ethics consultants not to abuse this power.

Many of the professional or academic backgrounds have codes of conduct governing potential abuse of power. Not all professions and setting do, however, and existing codes are neither uniform nor do they cover the specific role of ethics consultants. For this reason it is necessary to address some important potential abuses of power.

1. Ethics consultants have access to privileged information including highly personal medical, psychological, financial, legal, religious, and spiritual information. The requirements of confidentiality must be respected.
2. If ethics consultants have significant personal or professional relationships with one or more parties that could lead to bias, that relationship should be disclosed and/or the consultants should remove themselves from the case.

3. Individuals should never serve as ethics consultants on cases in which they have clinical and/or administrative responsibility.
4. There is a potential conflict of interest when ethics consultants are employed by a health care institution or their jobs are dependent on the good will of an institution. Giving advice or otherwise acting against an institution’s perceived financial, public relations or other interest may pose potential harms to ethics consultants’ personal interests. This issue should be addressed proactively with the health care institution. If the conflict of interest in an individual case puts ethics consultants in the position of shading an opinion to avoid personal risk, they should either take the risk or withdraw from the case.

5. Ethics consultants should never exploit those persons they serve by using their position of power. Ethics consultants, for example, should not take sexual or financial advantage of those they serve.

The above-mentioned cautions should be discussed and explained thoroughly in the training of ethics consultants.

§ 5.2 *Institutional Obligations to Patients, Providers and Consultants*

The dangers of abuse of power and conflict of interest can be mitigated if health care institutions take seriously their obligations to those who provide and utilize ethics consultation services. When patients, families, surrogates, or health care providers seek assistance in sorting through the ethical dimensions of health care they deserve assurance that those who offer that assistance are competent to do so and can offer that assistance free of undue pressure. We have discussed in detail how important it is for those who do ethics consultation to take seriously quality assurance and improvement. We have also underscored the dangers of abuse of power when health care institutions must be responsible to those who utilize ethics consultation services by providing support for ethics consultants in their institution. This support is needed in three areas.

1. Health care institutions should support a clear process by which ethics consultants are educated, trained and appointed, and provide resources for those who offer ethics consultation to ensure that [consultants]
have the competencies to perform ethics consultation. This will require support for continuing education and access to core bioethics resources (such key reference texts, journals, and on-line services).

2. Health care institutions should ensure that those who offer ethics consultation are given adequate time and compensation for non-remunerative activities, and resources to do ethics consultation properly.

3. Health care institutions should foster a climate in which those offering consultation can carry out their work with integrity (e.g. a climate free of concerns about job security, reprisals, undue political pressure). This should include separating ethics consultation from personnel oversight, so that healthcare providers see ethics consultation as a resource for addressing ethical difficulties rather than as a disciplinary action, and respecting the independence of ethics consultation and ethics policy initiatives. In such a climate pressures to abuse power or give in to conflict of interest will be significantly diminished.22

Full professionalization has never been instantly attainable by any field and while the ASBH’s efforts at professionalization are open to criticism, its inability to instantly professionalize is not the standard by which it should be judged.

This code speaks eloquently to rebut Scofield’s accusations that the task force’s primary concern was self-interest, rather than the public interest. The evident concern is to protect patients against abuses of power in the name of ethics consultation and to enable ethics consultants so that they can carry out their tasks with integrity.

Current Efforts to Create a Code of Ethics for Clinical Ethicists

As Scofield observes, the ASBH is currently developing a code of ethics. Ever the impatient perfectionist, instead of celebrating progress towards professionalization, Scofield scorns the effort, asking “why now?” The answer, in part, is that, historically, precatory codes of ethics mark entry into the second stage of professionalization. In the case of bioethics, I have published a series of papers, some cited by Scofield, chronicling the sequence of events that over the course of the last decade led both the ASBH and the Canadian Bioethics Society (CBS) to begin developing codes of ethics.23

The precipitating incidents began to unfold in 1997 when bioethicists in Canada and the U.S. who defended patients’ rights found their continued employment in jeopardy. The best-documented case involves Mary Faith Marshall, former director of the Medical University of South Carolina’s (MUSC) bioethics program. Marshall’s defense of a patient’s right to be informed before entering an experimental program led MUSC to terminate its bioethics program, and thus Marshall’s employment. Marshall gave offense by testifying under subpoena that MUSC’s “policy [on managing pregnant addicted Medicaid patients] fails to meet the institution’s norms or standards that have to do with informed consent... [because] the risk of ... arrest and incarceration was not made clear to the patients;”24 MUSC subsequently tried to deny Marshall promotion and ultimately terminated its bioethics program. Similar, albeit less publicly documented incidents were occurring — and continue to occur with disturbing regularity — when American and Canadian bioethicists, trying to protect patient or research subjects’ rights, have their continued employment threatened or terminated by institutional employers.

CBS responded by developing a draft of a model code of ethics and a Working Group on Working Conditions for Bioethics.25 Since the ASBH constitution had not authorized investigating or censuring institutional violations of professional integrity or academic freedom, the ASBH’s first response was to gain such authorization. In August 2002 the ASBH membership voted to amend its by-laws to enable it to “adopt positions ... relat[ing] to academic freedom and professionalism in ... bioethics,” thereby taking its first step towards professionalization.26 Many members of ASBH felt that this commitment required the ASBH to spell out what it meant to act as “a bioethics professional” by developing a code of ethics. Around this same period, in 2002, a joint ASBH and American Society for Law, Medicine & Ethics (ASLME) task force published voluntary guidelines on Bioethics Consultation in the Private Sector in response to concerns about the need for standards to handle conflicts of
interest for bioethics consultation in the private sector (e.g., for biotech and pharmaceutical companies).\textsuperscript{27} By 2004 the ASBH had formed a Task Force on Ethics Standards, and the ethics of bioethics was the subject of an ASBH-sponsored spring conference, where attendees discussed a draft code of ethics for bioethicists.\textsuperscript{28} The issue gained additional traction as ASBH President Arthur Derse urged “Ethics Standards for Bioethicists”\textsuperscript{29} and as an ASBH Taskforce endorsed a code of ethics at the 2005 ASBH annual meeting.

A survey of ASBH members found that they supported a code of ethics for bioethicists by a ratio of 3.6 to 1.\textsuperscript{30} Not surprisingly, the issues ASBH members thought a code should address were those that had proved vexatious. About 9 in 10 ASBH members believe that a code of ethics should address the following:

- identifying and disclosing conflicts or interest (ASBH-ASLME Report);
- confidentiality and obligations to disclose (Canadian incidents);
- reporting serious misconduct (the Marshall Case);
- improper pressures by employer/supervisors (the Marshall Case); and
- ascribing (co) authorship and crediting contributors to published work.

About 7 in 10 members thought that a code of ought to address the following two issues:

- presenting incomplete characterizations of complex issues in public venues (The Terry Schiavo case); and
- obligations to report problems to employers, supervisors.\textsuperscript{31}

The survey was delivered online and publicly at the October 2006 ASBH national meeting. Overall the survey found that ASBH members expect a professional code of ethics to project a field’s integrity by defining for employers, the public, new entrants to the field, other professionals and, most importantly, members themselves, what it means to practice the field with integrity. Over 8 in 10 ASBH members believe that a code should be mandatory, disciplining members who violate it.\textsuperscript{32}

Following up, at the October 2007 national meeting the ASBH board experimented with a workshop model of code development that a member, Kenneth Kipnis, had used to develop codes of ethics for other professionalizing fields. Encouraged by the success of this workshop, the board appointed a committee, led by Kipnis, to use the workshop/focus group method to draft a code of ethics for clinical ethicists.

As impatient as Scofield or I might be with the ASBH, we should recognize that it has embarked upon this journey and that it is moving, perhaps over-cautiously but nonetheless consistently, to professionalize bioethics. The challenges the ASBH faces of designing a code of ethics for a professional society representing a multidisciplinary field cannot be overestimated.

Judged by any reasonable standard — by comparison with the pace of professionalization in the ABA or the AMA — the ASBH is professionalizing bioethics at a reasonable pace. None of Scofield’s outrage or invective seems deserved. As I sought to illustrate with vignettes from the history of the professionalization of the ABA and the AMA, a field’s journey towards professionalization is typically long and seldom straightforward. As impatient as Scofield or I might be with the ASBH, we should recognize that it has embarked upon this journey and that it is moving, perhaps over-cautiously but nonetheless consistently, to professionalize bioethics.\textsuperscript{33} The challenges the ASBH faces of designing a code of ethics for a professional society representing a multidisciplinary field cannot be overestimated. If the history of professionalization teaches nothing else, it teaches that if we wish the professionalization process to succeed, then it is imperative to cultivate what is perhaps the least American of all virtues: patience.

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References
2. Scofield’s expression, “medical ethics consultation,” is a misnomer. It is not standard usage in the field because it seems to define clinical ethics consultation as the prerogative of medical practitioners, i.e., of physicians and surgeons. Given
the multidisciplinary nature of hospital ethics committees and the multidisciplinary background of clinical ethics consultants — many of whom, like Scofield, have backgrounds in law, or religion — a more appropriate description, and the characterization that is standard throughout the literature, is "clinical ethics consultation" or simply "ethics consultation."

Some definitional clarifications: by "bioethics" I mean the multidisciplinary field whose members are united by the common purpose of analyzing, researching, studying, and/or attempting to address, mediate, and/or offer solutions, or resolutions to ethical problems arising in biomedical science and healthcare. The term "bioethics" (first published use, 1971) encapsulates a paradigm shift from the older paradigm/conception/discourse of "medical ethics." The expression "medical ethics," initially a neologism, was first formally articulated by a British physician, Thomas Percival (1740-1804), in his eponymous work Medical Ethics (T. Percival, Medical Ethics: Or a Code of Institutes and Precepts, Adapted to the Professional Conduct of Physicians and Surgeons [London: J. Johnson & R. Bickerstaff, 1803]). Percival conceived of medical ethics as the self-regulatory ethics of professional physicians and surgeons, governing their own conduct and their relations with their peers, their profession, their patients, and the public. From Percival to the present day, medical ethics and its discourses are always privileged professional medical perspectives.

In striking contrast to medical ethics, bioethics is a multidisciplinary field addressing ethical issues in the biomedical sciences, as well as in health care, without privileging physicians' (or scientists') conceptions or discourses — hence bioethicists' insistence on a non-professional presence on hospital ethics committees and their emphasis on concepts like autonomy and respect for persons as a counterweight to professional authority. The multidisciplinary nature and anti-elitist stance endemic to bioethics creates significant challenges to the professionalization process and is a factor in the cautious approach bioethics organizations have taken towards professionalization.

3. See Scofield, supra note 1, at 100.
4. Id., at 100.
5. Id., at 96.
6. Id., at 106.
7. Id., at 108.
8. Id., at 109.
9. Id., at 110.
10. Licensure is neither a necessary nor a sufficient condition for professionalization. Medicine was and is recognized as a profession even in jurisdictions that did not or do not require licensure, and occupations requiring licensing, from barbers and beauticians to contractors, electricians and realtors, are not deemed professions because they do not self-regulate in the name of some public good. For a discussion of the development of codes of ethics in professions see R. Baker, "Codes of Ethics: Some History," Perspectives on the Professions 19, no. 1 (2000): 3-6, at the Center for the Study of Ethics in the Professions at IIT, available at <http://ethics.iit.edu/perspective/pers19_1a1898_2.html> (last visited December 1, 2008); See also R. Baker, "A Draft Model Aggregated Code of Ethics for Bioethicists," The American Journal of Bioethics 5, no. 5 (2005): 33-41.
11. The ASBH represents bioethics, which is a multidisciplinary field. Most members self-identify with more than one field: approximately 4 in 10 self-identify with medicine; 3 in 10 with philosophy; between 1.2 and 1.5 in 10 with humanities, religion, public health, law and nursing. R. Baker, R. Pearlman, H. Taylor, and K. Kipnis, Report and Recommendations of the ASBH Advisory Committee on Ethics Standards, American Society for Bioethics and the Humanities, 2006, at Tables 2.3, 2.7, available at <http://www.asbh.org/membership/protected/pdfs/acessrpt.pdf> (last visited December 1, 2008); Only four of these fields — medicine, law, public health, and nursing — have national societies professionalized to the extent of offering codes of ethics. Of these, the longest professionalized are in medicine (AMA) and law (ABA). These fields were chosen as the comparison against which to measure the progress of the ASBH. Center for the Study of Ethics in the Professions, "Codes of Ethics On-line," Institute of Technology, Chicago, available at <http://ethics.iit.edu/codes/codes_index.html> (last visited December 1, 2008).
14. N. Davis, History of Medicine, with the Code of Medical Ethics (Chicago: Cleveland Press, 1903): 142-143.
15. "On examining a great number of codes of ethics adopted by different societies in the United States, it was found that they were all based on that by Dr. Percival, and that the phrases of this writer were preserved, to a considerable extent, in all of them. Believing that language that had been so often examined and adopted, must possess the greatest of merits for a document such as the present, clearness and precision, and having no ambition for the honors of authorship, the Committee which prepared this code have followed a similar course, and have carefully preserved the words of Percival wherever they convey the precepts it is wished to inculcate. A few of the sections are in the words of the late Dr. Rush, and one or two sentences are from other writers. But in all cases, wherever it was thought that the language could be made more explicit by changing a word, or even a part of a sentence, this has been unhesitatingly done; and thus there are but few sections which have not undergone some modification; while, for the language of the name, and for the arrangement of the whole, the Committee must be held exclusively responsible." I. Hays, "Note to 1847 Convention," in R. Baker, A. L. Caplan, L. L. Emanuel, and S. R. Latham, eds., The American Medical Ethics Revolution (Baltimore: Johns Hopkins University Press, 1999): at 315.
16. The Code of Ethics adopted by the Alabama Bar Association in 1857 was adopted from Professional Responsibility (1854) by Judge George Sharswood (1810-1883) and from A Course of Legal Study, a textbook published in 1836 by David Hoffman (1784-1854). See American Bar Association, supra note 12.
17. The ASBH was prudent not to endorse the code of ethics in the Core Competencies report. No one in bioethics was interested in a code at that time. Moreover, as a first attempt at a code, the Core Competency code was too immature to serve the needs of the field. Consider these points in turn. Immediately upon publication the Core Competency report was widely discussed in the field but the section on the code of ethics was not cited in the literature and had little impact — the field was not thinking of nor was it ready for a code of ethics. Thus, the authors of the code never sought an organizational imprimatur or sanction for it. Moreover, to turn to the second point, the code that they drafted was not conceived as a professional code for the field, but as an honor code for individuals. Thus, ethicists are portrayed as isolated practitioners whose sole guide is a sense of personal conviction. The report notes that when ethicists give "advice ... against an institution's perceived ... interest" which "may pose potential harms to ethics consultants' personal interests" (5.1.4, emphasis added), it is the ethicist's personal responsibility not to "shad[e] an opinion to avoid personal risk" and the individual ethicists' personal responsibility to "either take the risk or withdraw from the case" (5.1.4). Notably absent are the concepts of profession and professional responsibility. Clinical ethicists are not envisioned as members of a pro-
fession, accountable to professional peers and to the public for responsibilities delineated by their role as ethicists, but rather as solo practitioners responsible — not to the profession collectively — but to their own personal conscience. Not surprisingly, since this first code of ethics for clinical ethicists portrays the responsibilities of bioethicists entirely in terms of personal belief rather than professional responsibility, it would have been unsuitable as a code of professional ethics. The Core Competencies code is thus a step towards stage two, not a code suitable for the field of bioethics as it will emerge as a full stage three profession. American Society for Bioethics and Humanities, The Report of the American Society for Bioethics and Humanities on Core Competencies for Health Care Ethics Consultation, Glenville, Illinois, 1998.

18. Id. (American Society for Bioethics and Humanities), at 1.


20. Significantly, AMA physicians were able to give criteria for who was not a regular physician: “no one may be considered a regular practitioner … whose practice is based on an exclusive dogma, to the rejection of the accumulated experience of the profession, and of the aids actually furnished by anatomy, physiology, pathology, and organic chemistry” (1847, Chap II Art. IV, Sec. II, Baker et al., supra note 15, at 329). They could not explain who a “regular” practitioner was, but they knew that anyone who embraced a practice inconsistent with known medical science (like homeopathy) were not “regular” practitioners.

21. Scofield alleges that the task force was indifferent to field-wide problems.

22. The charge of embezzlement rests on an anecdotal report in which an ethics committee member is alleged to have embezzled from a charitable organization (see Scofield, supra note 1, at 105). The charge of sexual misconduct is based on the American Psychiatric Association’s (APA) 1992 expulsion of the psychiatrist, Charles Culver, a well-known writer on psychiatric ethics, for violating the APA code of ethics’ prohibition against having sexual relations with patients. Neither of these allegations offers evidence of abuse of the role of ethics consultant; i.e., the alleged abuses — the embezzler’s violation of the law, Culver’s abuse of the psychiatrist-patient relationship — were not abuses conducted by someone playing the role of clinical ethics consultant. In each case, moreover, a single allegation is held to indict the entire field of clinical ethics consultation. There was not in 1998, nor is there now, any evidence of wide-spread abuse of trust or of power on the part of clinical ethics consultants or of hospital ethics committee members.

Scofield’s allegation of “charlatanism,” moreover, is specious on its face. No one can be charged with being a clinical ethics or bioethics “charlatan,” i.e., a pretender to competence, since the field has yet to develop standards of competence. Bioethics will be well advanced along the path of becoming a profession when it reaches the point at which some clinical ethicists can properly said to be “charlatans.” In an ironic but profound sense, charlatanism is a hallmark of professionalization.

23. See American Society for Bioethics and Humanities, supra note 17, at 29-30.


29. The April 7-9, 2005 ASBH conference, “The Ethics of Bioethics,” was organized by Robert Baker, Union Graduate College; Arthur Derse, President, ASBH; Matthew Wynia, President-Elect, ASBH; and Glenn McGee, Alden March Bioethics Institute. It was held at Union College in Schenectady, NY. One focal point was discussion of a proposed draft of a model code of ethics for bioethicists. See Baker, supra note 10.


31. See Baker et al., supra note 11, at Table 3.1.

32. Id., at Table 3.4.

33. My reasons for insisting on matine are different from Scofield’s. On my analysis, professionalization forces fields to address existential questions: Who are we? Whose interests do we serve? How do we serve them with integrity? By focusing narrowly on clinical ethics consultation the ASBH’s code initiative avoids probing these definitive existential issues. One can appreciate such caution. Bioethics was conceived by accident and exists in large measure only because of America’s predilection for legitimating successful pragmatic innovations. In the 1960s and 1970s, faced with the perceived fearlessness of traditional medical ethics in the wake of scandals involving human subjects research and frustrated by traditional medicine’s seeming inability to deal with ethical issues arising in organ transplantation and critical care, agencies of the U.S. government, private American foundations, and the American media turned to multi-disciplinary teams of administrators, health professionals, lawyers, philosophers, scientists, social scientists, and theologians to devise new regulations and policies. As these teams proved successful in developing, disseminating and administering effective policies they came to be known as “bioethicists,” eventually formed the societies that a decade ago united to create ASBH.

One suspects that the ASBH board fears that if it challenges members to settle upon a code that speaks to their common interests, they may find that they have few interests in common and centrifugal forces will spin ASBH off into fragmenting parts. (See, for example, the editorial by

ASBH members themselves, however, appear less timorous: more than 7 in 10 agreed that a code of ethics should focus broadly on standards applicable to all members. They seem to appreciate that a code that deals only with clinical ethics consultation will not address most of the issues of confidentiality, conflicts of interest and collegial relationships that they face in their day-to-day work as educators, scholars, and as research ethics committee members (Baker et al., *supra* note 11, Table 3.3b). The reasons that ASBH members prefer a broad code ethics, rather than a code focusing only on clinical ethics, are evident from the demographic data. Bioethicists play multiple roles: More than 4 out of 5 work in a health related field, more than 7 of every 10 engage in research or scholarly activities, 3 out of 5 serve as ethics consultants or serve on an ethics committees, 2 in 5 serve on IRBs/REBs, 1 out of every 3 teaches in non-health related fields, around 1 in 5 serve as a bioethics consultant outside of clinical and academic contexts, while 1 in 10 serves as an expert witnesses (see Baker et al., *supra* note 11, at Table 2.5). A code focusing on only one dimension of their work—clinical ethics — was favored by only 3 out of 10; nearly half thought this a bad idea (see Baker et al., *supra* note 11, at Table 3.3b). A narrow code of ethics focusing only on clinical ethics consultation will not address most of the activities ASBH members engage in as bioethicists.