The first task in an essay of this sort is to identify what distinguishes the topic – professional ethics – from other areas of ethics. My aim, thus, will be to explain what makes professional ethics distinctive and to discuss its critical role within broader concerns in practical ethics. The thesis is that the practice of professions has a structural normativity: To accept the role of a professional is to have a moral commitment to the acquisition and reliance on a technical expertise practiced, first and foremost, in service of one’s client’s vital needs. This commitment thus creates, reflects, and reinforces the normative foundation of professionalism: A professional/client relationship rooted in trust.

Establishing that thesis requires, first, an elucidation of the features that separate genuine professions from the many jobs and businesses that, although they are largely instrumental in practice, at least on occasion and mainly for economic benefit, self-identify as professions. These include everything from athletes (“Bureau of Labor Statistics”) to beauticians (“Beautician”) and gardeners (“Association of Professional Gardeners”). Professions’ distinguishing features, I will show, are revealed via historical review of the development of the traditionally recognized formal professions in combination with a conceptual analysis of the meaning of key terms.

From these I will conclude that in addition to the fiduciary foundation, there are three central criteria (along with a number of corresponding common features), that identify professional activity as distinct: Expert service provided on behalf of vital matters; specialized knowledge; and autonomous self-regulation.
I then use these criteria to place specific occupations along the continuum of professionalization, ranging from those in which the relationship with the customer/client is wholly instrumental (car sales is often an exemplar) to those in which the fiduciary commitment is the defining standard of the relationship (e.g., accountancy). I will also discuss some common ethical issues that arise within the professions and will close with a brief discussion of the impact of “democratization” on the analysis and social practice of the professions.

Making Sense of “Profession”

In his influential 1981 book, Professional Ethics, Michael Bayles argues that the best way to understand the nature of professions is through an analysis of what, in fact, distinguishes them in social practice. In defense of this largely empirical approach, he cautions against assuming normative criteria: “One may,” he says, “bias an investigation of professional ethics by using normative features (those saying how matters should be) to define or characterize professions” (Bayles 1981: 9). He then provides a particularly scurrilous description of lawyers, given in 1930 by George Sharswood (one of the first scholars of legal ethics), as grounds for rejecting normative assumptions. Although lawyers are clearly recognized professionals, they are also, Sharswood tells us, “a hord of pettifogging, barratrous, custom-seeking, money-making scoundrels” (Bayles 1981: 9) (see LEGAL ETHICS).

While that description is at best an overblown characterization of lawyers’ ethical standards – then and now – it reveals the problem with assuming some essential normative feature to define professions: What should be done with those enterprises that are widely recognized as professions, or who call themselves such, but which do not have that normative foundation? As noted above, examples abound and the bulk of those who participate in those occupations are undoubtedly ethical, striving to perform as competently as possible and to treat their clients, customers, and fans fairly. But, again, those relationships are largely instrumental. That is, they are grounded primarily in economic considerations without the sort of defining normative characteristic – that participants will have the well-being of those clients, customers, and fans as their first priority – that motivate professional relationships. Contrast, for example, the motivating
forces present in a simple exchange of material goods versus those present in one’s relationship with one’s family physician, engineer or accountant

When Bayles’ book was published, groups called themselves “professionals.” He focused on the historically recognized professions like law, medicine, engineering, and the academy. From these he concluded – empirically, he says – that the way to pick out the professions is to recognize both their “essential features” and those “commonly present” in recognized professions. The former, he says, are “extensive training,” a “significant intellectual component,” and “important service in society,” while the latter include “certification or licensing,” an “organization of members” (committed both to internal regulation – typically through a code of ethics – and to lobbying), and considerable autonomy over work practice (Bayles 1981: 7–8).

The current diversity, however, of self-identifying professions, many of which have none of the essential features and few of the common ones, reveals that a merely descriptive, sociological, approach is inadequate. That is, we need either a broader list, one that includes all those that self-identify as professions, or a narrower one that genuinely picks out the legitimate professions. Since the thesis of this essay is that professional ethics represents a distinct topic within ethics, the broader list will not suffice, as then there would be no difference between business and professional ethics and no way to characterize the special role-based duties present for professionals. More importantly, a review of the historical development of the paradigm professions reveals that a core normativity was a central consideration in their establishment, particularly in their being granted self-regulatory authority, economic monopoly, higher earnings, and social status. That is, they became professions because they defined themselves via a pledge to express their expertise through a fiduciary relationship between professional and client. Let us thus turn to medicine’s history as a paradigmatic example.

<ha>Historical Background
<p>The etymology of the term reveals that, historically, professionals professed on matters of great importance, having acquired the learned capacity and experience that would warrant greater trust in their knowledge and skills. Thus, despite the prevalent
joke about prostitutes being the oldest profession, the earliest was the clergy. For believers, there could be nothing of greater importance, and spiritual leaders were singled out for their wisdom and access to truth.

As societies became more complex and as knowledge became more scientific and technical, truth claims came via experience, reason, formal education, and trust in one’s colleagues’ findings (Hardwig 1991: 700–2), rather than through appeal to sacred texts or privileged access. This impacted not just technique-driven activities like medicine and construction design, but political governance and, through that, the law. Thus the ranks of proto-professions expanded beyond clergy to include physicians, engineers, and lawyers, along with their educators, university professors.

As these groups became increasingly successful, people began to rely on them to manage the associated complexities of life. “Clients” saw in them a new kind of expertise, one that provided genuine solutions to vital concerns and one that thus warranted substantial compensation. But with that economic incentive also came persons claiming the ability to provide similar solutions, but who were, often as not, mere frauds.

Seeking a way to distinguish themselves, the genuinely trained and skilled created formal bodies that provided assurance to clients that they were the real deal. Medicine was the first to make this official move when the eventually named British Medical Association (BMA) founded in 1832 (see BIOETHICS). Shortly thereafter, the Association took on the role of determining the qualifications one must have to be deemed a physician and, later, the accrediting requirements for medical education. The American Medical Association (AMA) followed suit in 1847, setting a normative stage at their inaugural meeting by establishing the Association’s first Code of Ethics. That act was intended to convince clients and politicians that members were different: They could be trusted both to have the requisite skills and knowledge and to have their primary motive the promotion of their patients’ interests. Full adoption of these criteria emerged in fits and starts, getting a key boost from the Flexner Report on US Medical Education (Flexner 1910).

In the sciences, epistemic trust is granted through confidence in the research systems and processes, as well as in the character of scientists (Hardwig 1991: 701–2).
There is also the promise/threat of replication: Because one knows one’s reputation is on the line if results cannot be independently confirmed, prudence dictates experimental diligence (see RESEARCH ETHICS). For clients in professional contexts, such replication is available only through second opinions, a limited option for most, given economic and time constraints, and given the power differential between client and professional.

Trust in medical professionalism is thus generated both implicitly by the system that socializes professionals through proper training, experience, oversight, and prioritization of client well-being, and explicitly by the individual physician who emerges from that system and who commits to a fiduciary relationship with her patients. Building confidence in the system and its individuals was a key motive of the BMA and AMA and the various actions they took successfully convinced legislators to grant them a monopoly on the provision of medical services.

Thus from their very founding, the BMA’s and AMA’s respective structures had 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; on the other hand, they also 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 abuse her status for personal enrichment, all while claiming a privileged standing. To balance this tension, the Association had to inculcate a structural commitment to a fundamentally normative status: Medicine was not just a job or even a career; it was a calling, one dedicated to the highest medical knowledge and to an avowed commitment to placing patients first.

While this structurally normative approach was hardly perfect – plenty of physicians take advantage of the tremendous power attached to their role – it was largely successful in distinguishing authentically professional healthcare professionals 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 and engineering.

As I will discuss below, however, this history took a sharp turn in the 1980s, as the professions became, in William May’s (2001) 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.

<ha>Definitional Criteria
<p>The historical development of the paradigm professions suggests, thus, two points: First, a commitment to a normative, fiduciary, foundation – understood as both implicit and structural, and explicit and personal – was key to the professions acquiring their distinctive status; and, second, such normativity characterizes the genuine professions. As I explain below, the normative commitment becomes a kind of meta-criterion, one that both emerges from the other criteria and also informs them.

What, then, are those criteria? Since an empirical review of those activities that self-identify as professions results in a far too inclusive list, we need, as Michael Davis explains, a philosophical or conceptual analysis (Davis 2010: 94–5). Such an approach considers what is necessary to the meaning of the concept and thereby reveals what makes professional ethics unique.

Such an analysis produces a list of three necessary conditions. Similar to Bayles’ essential features, they are nonetheless determined conceptually rather than empirically. By contrast, an empirical analysis does provide insight into professions’ common features by showing how they naturally emerge when the essential features are put into practice; that is, the necessary conditions produce, in practice, related common features, features that reinforce the activity’s status as a profession.

<hb>Provides a vital service
<p>Persons seek help for a wide variety of problems, ranging from advice on where to get a good meal, to whether headaches are indicative of a tumor. If the meal advice is flawed, you shrug it off and dine elsewhere next time. If the headache advice is flawed, you might well die.

Among the many things humans deeply value are health, liberty, economic stability, protection from dangers human and natural, spirituality, and education. These are of such great importance – Bayles calls them, or at least a similar list, the “values of a
liberal society” (Bayles 1981: 5) – that they carry a corresponding degree of vulnerability, such that when they are threatened, associated advice needs to come from someone with genuine expertise: a professional.

Of course, not all vital matters are managed by professionals. Contemporary social and economic conditions have created, for example, an essential dependency on digital devices and the experts who help us manage them. While software and hardware engineers clearly have professional status, the same cannot be said about those who do the bulk of the service work, e.g., helpdesk workers, (many) web designers, and hardware assemblers. Nor can it be said of plumbers or electricians, though their services are also vital to modern living.

But the reverse holds: To be a professional is to be engaged with a vital matter and to have the relevant expertise to be of trustworthy assistance. To again contrast the professional’s role with two of those who falsely self-identify as such, paying too much for a car may annoy, but there is nothing life-altering at stake, and getting a bad haircut can be temporarily embarrassing, but hair grows back or the person down the street can fix the damage. Compare these, though, with what happens when, say, the engineer who designed the car’s brakes is incompetent or trying to make more money by cutting corners; or when the hairdresser does not recognize that hair falling out is an indication of a critical nutritional deficit. For these, one needs a professional. Similarly, we generally do not know how to fix our own bodies, build our own bridges, interpret arcane legal language or procedures, or design a home that can withstand an earthquake – all of which are critical to sustaining vital values.

The vulnerability that results from relying on others to assist with a vital need produces two common features of contemporary professions: Client dependency and asymmetrical power relations. These emerge both from the nature of professionals’ superior knowledge and from contingent but widespread social practices in which clients are socialized into treating professionals with deference.

The typical professional–client encounter has built into it the mutually reinforcing psychology of client fear and professional superiority. Both are in part natural and warranted: one sees a professional precisely because something of great importance is threatened. They are also inculcated via social artifice: professionals expect clients to
be deferential and this is socially reinforced from an early age through such mechanisms as medical attire, the trappings of an attorney’s office, elevated judges’ platforms, clergy robes, and the titles attached to academicians. Some amount of deference is appropriate when the professional is genuinely an expert and is ethically committed to the task, in which case the client is deferring as much to the valid authority as to the person. But combine the social inculcation with real fear and the resulting power asymmetry provides a rich opportunity for abuse: thus, again, the importance, again, of the fiduciary foundation.

Sometimes the asymmetry and associated deference can be reassuring to all parties, but seldom is it also promoting of client autonomy (see AUTONOMY); hence the range of now ubiquitous legal mandates of autonomy-enhancing practices. The informed-consent movement in medicine is paradigmatic, but it is also reflected in do-it-yourself kits for divorces and wills and in the proliferation of non-traditional models for higher education (e.g., MOOCs and compressed degree programs).

Client autonomy, however, is not of absolute value. The power granted to professionals is and should be profound; e.g., one must still obtain a prescription for many medications and, in any but the simplest of legal cases, one is foolish to try to represent oneself. Furthermore, client wishes sometimes conflict with professional values (e.g., physician-assisted suicide) (see SUICIDE) and sometimes the professional is obligated to use her knowledge and experience to convince a client that her choice is not consistent with a rational life-plan. Thus, despite the autonomy movement, professionals still clearly wield the power in professional–client interactions, especially in medicine (Meyers 2007: 63–87). Finding the proper balance between the appropriate authority attached to professional expertise (and autonomy) and clients’ autonomous right to self-determination is one of the specific issues I discuss below.

<hb>Education, specialized knowledge</hbp>

Acquisition of the relevant expertise nearly always requires extensive education, whether formal, self-taught, or via apprenticeship. This is especially true in those societies in which professionals have become ever more specialized. For example, in the United States, civil engineers now can specialize in seismic requirements, surgeons
in feet and ankles, lawyers in entertainment contracts, and philosophers in early Medieval. And each needs the education necessary to acquire the required information and skill sets.

Early professionals mostly gained the necessary knowledge and skills through apprenticeship (May 2001: 2). But as they established themselves as key groups in society, education was largely relegated to universities, with curricula closely prescribed by the respective accrediting agencies. By the 1950s, in the United States, a Bachelor’s degree was a minimal requirement, with most established professions requiring at least a Master’s, more likely an MD, PhD, or other terminal degree. Social status soon followed; as Everett C. Hughes puts it, “one way in which an occupation … can document its high status is by being able to take its pick of the young people about to enter the labor market, and then to keep them in school a long time before admitting them to the charmed circle” (Hughes 1988: 34). And education does not stop with the degree. Law, medicine, social work, and professional engineering all require ongoing continuing-education hours.

Among the common features associated with professions’ strong educational emphasis and specialized knowledge and skills are the now very powerful accrediting organizations, groups that can dictate not only education standards, but often the very way the profession is practiced. Another is the dominance of technical language, language that serves both as shorthand for members and as a way of reaffirming membership (which again contributes to the asymmetrical power that constrains client autonomy). A third is that professionals are engaged primarily in mental work, though surgeons and architects, for example, must also be physically adept.

Self-regulation/autonomy

Probably the greatest social benefit afforded professions is the power to self-regulate. Lawyers decide whether their colleagues have committed malfeasance; clergy determine the criteria for ordination; and faculty judge whether colleagues should be tenured. While some of these professions are also subject to state licensing (with some associated, if limited, regulation), it is the professionals who determine even those criteria and licensing also creates a state-sanctioned monopoly. For example, only
physicians may perform medical procedures or, as noted, prescribe medications, and only those who have passed a state’s Bar may practice law.

Similarly, while there is increasing oversight of professionals’ activities, most still have tremendous autonomy in their practice. For instance, while accrediting agencies are demanding more evidence that their activities (teaching, research, and service) are successful, professors still have nearly complete control over course content and methodology (so long as their peers deem their efforts to be successful). Similarly, medicine is rightly called an “art,” rather than a strict objective science, because there is so much judgment-based variability in its practice (Nuland 2008; Gwande 2003). And, again within minimal legal constraints and peer evaluation, there is a wide range of nuanced difference in treatment, even in diagnosis.

Such variability is tolerated, even encouraged, both because the matters with which professionals are concerned are complex enough as not to allow for cookie-cutter models, and because the professional is assumed, per the education standards, to be sufficiently competent to be able to rely on their own acumen. Compare this flexibility with, for example, elementary teachers: Their curriculum is largely dictated by the state and local school board and, while they have some flexibility in style, oversight is far stricter than at the university level.

The autonomous self-regulation afforded professionals, however, makes it prima facie harder to retain public and client trust – thus, again, the need for confidence generated by the respective system. One can feel reasonably confident, for instance, that the legal strategy adopted by one’s attorney is the best, or at least good enough, because of the standards established by her professional organization. That is, one may feel confident in their lawyer’s skills because her state Bar provides sufficient oversight and continuing education.

The democratization movement of the last few decades emerged in part because that oversight has too often fallen short. Public trust has eroded as professions reorganized for economic advantage, and as the institutions many of them came to work for as employees emphasized their commercial as much as their service mission. Despite this, however, the traditionally identified professions still retain greater public confidence than most occupations and services; they do so precisely because the
public recognizes – directly or by implication – that when it works well, the professions’ insistence upon a structurally embedded self-regulation produces the appropriate systems-based protections.

All this has resulted in a number of common practice features: Nearly every profession has a group organization that also serves as an umbrella for accreditation bodies and for the subcommittees that create and promulgate ethics standards and that determine the standards governments use for licensing. They also manage the number of practicing professionals present at any given time by dictating enrollment in professional schools. Their monopolies thus are both legal and economic: by controlling the number of persons competing for the client pool, they can significantly impact pricing.

The normative underpinnings

Because the system of professionalism establishes that its members have the educated expertise to help meet clients’ vital needs while also providing appropriate oversight, clients appropriately trust that the professional will act rightly, i.e., competently and ethically. And, as the history reveals, great social and legal authority was granted to professions based on their clear and explicit commitment to make client well-being a first priority. That commitment thus underlies the system’s and its individuals’ distinctive dedication to proper expertise, oversight and trust.

Compare that pledge with most other instrumental business/commercial dealings: The customer gets a product or service and the merchant makes enough profit off it to keep the business afloat and to make a living. A smart business person treats customers fairly and with respect in order to get repeat business and to develop a positive reputation. And, of course, many business people are just plain good people, strongly inclined to treat others fairly and to establish and maintain good relationships with all their customers.

But caveat emptor is still the structural foundation of business relationships: Customers correctly approach commercial interactions warily, cognizant that the merchant’s purpose is to make money. Professionals, of course, also seek to make money and they generally are paid handsomely. Such compensation, though, is, or
should be, a *secondary* aspect of the encounter: The professional’s primary charge is to help facilitate clients’ successful resolution of matters of vital importance. Clients thus seek professional assistance presupposing the professional is not going to recommend treatments, procedures, or approaches that serve her benefit at the client’s expense.

This ethical commitment is reflected in a number of *common practice features*, including that professionals see their role as a *calling*, rather than as a job or even a career. Related, most believe they have a duty to provide *service to the community* (e.g., *pro bono* legal assistance) and they are generally *available 24/7* (often through rotating “call” coverage). These values are typically inculcated through an at least implicit *socialization process* whereby the professional is trained in a public-service mindset. Compare this, again, with the car salesman: His mindset is to sell cars, to make profit. That is a perfectly fine primary mindset; it is just not a *professional’s*.

None of this is to say that because the ethical standards are structurally present in the profession’s essential features, this therefore also means they are present in each professional or in every professional–client encounter. All the criteria admit of degrees; one can be more or less knowledgeable, skilled, and ethically dedicated, with specific levels dictated in part by character traits and the types of temptations and constraints discussed below.

In other words, to be a member of a formal profession is not necessarily to act *professionally*. (This also of course holds in reverse: many nonprofessionals have a deep ethical commitment to their clients and are quite skilled at what they do.) But such failure of professionalism is noteworthy precisely because it is contrary to the norm; the default is we can and should trust professionals to have their clients’ best interests at heart, a trust that generally should not be extended to strictly commercial and instrumental exchanges.

*Identifying the Professions*

We are now at a place to apply the criteria to contemporary occupations to determine which are plainly professions (or marginal or emerging ones). Those that qualify are physicians, lawyers, engineers, certified public accountants, veterinarians, psychologists, dentists, professors, pharmacists, ordained clergy, and architects. They
qualify because they fulfill all the criteria, even if some of them, some of the time, do not do so in a robust way (e.g., an engineer who works for a large firm and never has client contact, or a “freeway flyer” college professor, teaching isolated classes at multiple universities and thus with reduced autonomy and research opportunities).

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, here are some prominent examples:

<list>

System Administrators. They certainly provide a vital service and they are highly educated with a very specialized knowledge and technical skill. As they move toward a more formally established activity, with consistent education standards and credentialing, system administrators become increasingly professionalized. For now, however, they do not have a sufficiently developed or authoritative self-regulating organization nor is there a strong commitment to client well-being – indeed, there often is no clearly identifiable client at all. High level programmers fall in a similar place along the continuum and for similar reasons (see COMPUTER ETHICS).

Scientists. Those who are also college professors, or who have the relevant terminal degree but may work, e.g., for government, meet all the criteria. But those with lower degrees (Bachelor’s or Master’s) or who work for profit-based businesses, only marginally satisfy the criteria. 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. Nonscientific researchers (e.g., for law firms) are similarly situated (see RESEARCH ETHICS).

Nurses. Their commitment certainly aligns with the normative baseline (client well-being is their highest priority) and most consider their work to be a calling. But their autonomy is largely constrained by the medical hierarchy and educational levels vary significantly – ranging from Associate’s degree to Doctorate (see NURSING ETHICS). 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 or nation).

*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. And while they were once among the most highly regarded of workers, respected both for their commitment and for the knowledge necessary to effectively educate, that status has, for a number of complex reasons, largely eroded in recent years, as evidenced by the ever-increasing demands for assessment and standardized testing (see TEACHING ETHICS).

*Journalists.* Journalists have also lost much of the public trust they deservedly acquired during the Watergate area; 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 it is not at all clear who their client is: The public? Their publisher or station owner? Other journalists? The truth? (See JOURNALISTIC ETHICS.)

Other fields are becoming increasingly professionalized worldwide and likely will move into the formal ranks within the next half-century. Among these are some aspects of military service, especially the officer corps; subdisciplines within computing; telecommunications specialists; musicians, especially composers and conductors; and law enforcement, again especially within officer ranks.

*Specific Issues*
<p>The professions encounter all the same ethical problems as other human enterprises, in which moral ignorance, personal failure, and weak character often cause persons to act in ways that disrespects or harms others, treats them unjustly, or fails to provide appropriate benefit. In these respects, there is nothing special about
professional ethics. Some have in fact argued that problems in professional ethics are structurally the same as in all other areas of life; they are just made specific by the circumstances of professional–client relationships (Welch 2007). That specificity, however, is starkly revealed in the fiduciary underpinning of all professional-client relationships, with the professionals’ associated role-based duties.

Those special duties are the source for the most dominant ethical issue in professional ethics: conflict of interest (see CONFLICT OF INTEREST). A conflict of interest emerges as the result of damaged trust within a fiduciary relationship, that is, within relationships where the affected parties trust the others to act with their best interest in mind. This distinctive form of ethical failure occurs when conflicting factors damage the professional’s judgment or otherwise prevent her from acting on the client’s behalf, with such factors ranging from material gain, to power or status, to sexual enticement.

Because the fiduciary standard is so high for professionals, the potential for conflict of interest is correspondingly elevated. Again, I approach my relationship with a car salesman with the assumption that he is not motivated by my well-being; in that role he cannot, thus, he cannot have a conflict of interest toward me. When, by contrast, my physician accepts a Pfizer-sponsored junket to Hawai‘i, I can legitimately worry whether her judgment regarding prescription choices has been compromised. I should be similarly concerned if my lawyer has been dating opposing council; or if my professor, who grades on a curve, has received a nice bottle of scotch from another student. In each instance, the professional’s ability to cleanly act in the client’s best interests has been at least damaged, if not fully undercut.

A second predominant ethical issue for professionals emerges from their unique professional and organizational culture. As Patricia Werhane (1999) and Phillip Zimbardo (2007) have shown, even good-hearted, ethically concerned, caring people can be deeply influenced by organizational or professional circumstances – “conceptual scheme” or “script” (Werhane 1999: 47–67). Such scripts can motivate members to act in ways they might otherwise consider unconscionable (or, similarly, the reverse: persons of weak ethical character can be motivated by a positive culture to act rightly). Much of the point of socializing professionals is to deeply inculcate in them an ethical
mindset. When that mindset is a positive one, good behavior results; when not, the reverse.

Since a significant aspect of professional socialization includes becoming immersed in power, an arrogant, even abusive, script often emerges, with a range of corresponding ethical problems (e.g., paternalism, financial exploitation, and disrespect). This mentality is exemplified in cynical characterizations of physicians as “MDieties” and in the critical assessment that someone is “becoming a lawyer,” i.e., someone whose whole life exudes argumentation and superiority (Wasserstrom 1988). In short, the very socialization that can motivate truly professional behavior can also enhance a negative “professionalized” mentality (Wasserstrom 1988: 66–7).

Democratization

What it means to be a professional in the early part of the twenty-first century has changed substantially from what it meant in the mid-twentieth. Professions, and professionals, have become less autonomous, less effectively self-regulating, and much more business-like and thereby more beholden to corporate and for-profit interests. For example, physicians increasingly practice under managed care contracts or as part of large groups where ‘productivity’ is at least as important as quality of care. Even those who are hired as faculty members at a university-affiliated hospital are under growing pressure to produce a profit in their patient care. Collegiate faculty are facing similar pressures to increase student-faculty ratios and to respond to external regulators, particularly accrediting bodies.

While these changes have been most visible since the late 1980s, there were signs of them a decade earlier (Bayles 1981: 4–5). Around this time, patient autonomy became a mantra, the law was pushed to make some routine legal needs manageable without the use of an attorney, and governments – and shortly thereafter, insurance companies – took a more active role in key aspects of the provision of medical treatment. Related, if more recently, the Internet has made it easier for clients to acquire information on their own and thus to (often ignorantly) question or challenge their professionals’ assessments.
These changes, often reflected in changing media portrayals (compare, for example, television shows' characterization of physicians from the 1950s and 1960s with contemporary depictions), have contributed to a democratizing process wherein professionals’ power and authority have been significantly reduced. Some of this transformation was direct and intended, a result of the general challenge to authority in the 1960s and 1970s; some was a byproduct of a commercialization of the provision of professional services. The intended goal was to increase individual clients' power and choices and while this has in fact occurred, it has come alongside an even greater shift of power to corporations and government. One example: Technical and technological (including pharmaceutical) advances have occurred at such an astonishing rate that individual professionals are now deeply dependent on for-profit providers, e.g., drug representatives and software designers. This dependence has, in turn, increased the effective power of those providers, often at the expense of clients' well-being and professionals’ autonomy.

Democratization has also produced ethically positive results: Clients have greater autonomy and some of society's class disparity has diminished, in part because there has been an increase in access to key social institutions (women, for example, will soon make up the majority of US physicians). On the other hand, professionals have become less committed to the normative foundations of their respective enterprises and are instead increasingly focused on business considerations, with a corresponding increase in the conditions – especially the commodification of clients – that produce conflicts of interest (May 2001: 47).

There is some indication of a backlash against these negative impacts. An increasing number of medical schools are stressing an ethics curriculum and engaging in professionalizing rituals like the white-coat ceremonies. And the American Bar Association is undertaking a number of social justice initiatives (“Other ABA Initiatives”), with such programs also set against the backdrop of publications pushing for a more professional cadre of lawyers (Kronman 1995). The corporatizing and regulatory pressures, however, are great; the professional who retains the normative core does so mainly because of that sense of calling; she is in it for the right reasons, not just as another way of earning a living. That is, she is a genuine professional.
<xrefs>SEE ALSO: AUTONOMY; BUSINESS ETHICS; COMPUTER ETHICS; CONFLICT OF INTEREST; JOURNALISTIC ETHICS; LEGAL ETHICS; BIOETHICS; NURSING ETHICS; RESEARCH ETHICS; SUICIDE; TEACHING ETHICS

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<hx>Suggested Readings</hx>
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