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The moral organization of the professions: Bioethics in the United States and France

Raymond De Vries,
University of Michigan, U.S.A

Robert Dingwall, and
University of Nottingham, U.K

Kristina Orfali
Columbia University, NY, USA

Abstract

Bioethics is a relatively new endeavor, emerging as a discourse distinct from considerations of moral responsibility occurring within the professions of medicine and science. We use the ‘de-centered comparative method’ to examine how the emergence and development of bioethics varies across different social and cultural settings. In particular, we look at bioethical work in the United States and France, exploring these different manifestations of the movement toward external oversight of those working in medicine and the life sciences. The study of these varied processes of occupational development allows us to address two important issues. One is the way in which pathways of professionalisation are shaped by contingent cultural and historical factors. The other is the degree to which the increasing prominence of the bioethical occupation is the result of the professional desires of bioethicists and/or a concern for the public good.

Keywords

bioethics; sociology of the professions; regulation; sociology of medicine; sociology of science

Over the past forty years, biomedical issues that used to be the exclusive concern of physicians and scientists – from embryonic stem cell research to end-of-life care – have been increasingly colonized by other interested parties. In this paper we examine the emergence and growth of the most prominent of those interested parties, the relatively new occupation of bioethics. Using the ‘de-centered comparative method’ (Wrede et al., 2006)¹ we consider how the different social and cultural settings found in the United States (US) and France have shaped the content and boundaries of bioethical work. In the US, a social movement has been transformed, first into an increasingly self-conscious occupational group of bioethicists and more recently into a profession that is considering certification and licensure. In France, bioethics has remained a topic for expert debate and development within the medical and scientific community. The study of these varied processes of occupational development allows us to address two important issues. One is the way in which pathways of professionalization are shaped by contingent cultural and historical factors. The other is the degree to which the increasing prominence of the bioethical occupation is the result of the professional desires of bioethicists and/or a concern for the public good. We set the stage for our analysis with a brief review of sociological explanations of occupations and professions.

¹Decentred cross-national research is a method that uses researchers *from* the countries being studied – who understand ‘local knowledge’ – to develop key concepts and research questions. See De Vries et al. 2001 for an extended example.

Where do occupations come from?

“Occupation” is a term used in a classificatory scheme that helps us make sense of the rather messy world of work, paid and unpaid (Freidson, 1978; cf. Dingwall, 1983). History teaches us that occupations change along with changes in the division of labor and shifts in the kinds of work that society needs done. Some occupations disappear, like ostlers and stableboys. Some have contested boundaries (Wilensky, 1964): Who is a nurse? A Registered Nurse? Someone who looks after children in day care? A paid companion to a rich widower? Some occupations are created by new technologies and new fads and fashions, like software engineers, baristas, and pole dancers.

The Chicago sociological tradition represented by Freidson’s work uses a powerful metaphor to understand the organization of occupations. Think of all the work that has to get done in a society as the landform upon which a city is based. The division of labour is the street grid that defines this landform: some areas are zoned for manufacturing, others for services, some for respectable tasks, others for deviant ones; some areas are identified for the market, others for domestic labor. Each zone, or jurisdiction (Abbott, 1988), is a site for potential ecological struggle. Some are securely occupied by well-entrenched occupations. Others are scrapped over: some want to annex new areas to territory they already control; some wish to abandon a declining area in order to colonize a more desirable one; others desire to take over a neglected patch and displace or organize the existing occupants to improve it. This metaphor has its limits – landforms are less easily altered than material technology – nevertheless, it introduces a way to think sociologically about occupations.

One of the first questions about bioethics as an occupation, then, is where it fits into the contemporary ecology of work as defined above. This question is made more difficult by the fact that there is no precise definition of a “bioethicist.” As De Vries et al. (2006) note, the work of bioethics includes a broad range of activities: serving on national commissions; providing advice to the pharmaceutical industry; consulting at the bedside when there is conflict between and among caregivers, family members, and patients; reviewing research protocols; and writing for scholarly journals and the media. Those who claim the title of bioethicist also are widely varied: physicians, nurses, attorneys, social workers, psychologists, patient activists, theologians, philosophers, narrative theorists, historians, economists, anthropologists, and sociologists. There is, in fact, no way of preventing anyone from declaring, ‘I am a bioethicist,’ or challenging this claim once made. Because bioethics is truly a “profession in process” (Bucher and Strauss, 1961), it allows us to use the landform metaphor to explore how the professionalisation occurs. What is the zone or jurisdiction that bioethics is seeking to occupy? How are groups of workers establishing themselves with at least the minimal self-consciousness of a shared job title? Is this a vacant lot or one that is already occupied, so that ownership may be contested? Are bioethicists new immigrants or existing residents who have reorganized themselves to colonize new territory?

According to Freidson (1978), the world of work may be divided into four main taxonomic units, defined by the nature of the market for the labor being traded. In the *official* labor market, work is legally and economically recognized, included in measures of production and categorized in census lists of job titles. Alongside the official market for work can be found the *criminal* labor market, the *informal* labor market, and the *subjective* labor market. Freidson saw the last, where goods and services are traded without direct economic exchange, as both the cradle and the grave of many occupations.

Bioethics has always been part of the subjective economy, existing when and where people debated whether socially licensed experts were behaving properly. In the 1930s, Evans-Pritchard’s (1937) Azande discussed the integrity of their diviners in much the same way as

contemporary Institutional Review Boards (IRBs) discuss the integrity of researchers. Unlike the Azande, however, modern societies have developed an institutional system of official labor to conduct those debates in a formally rational fashion. That labor, though, has not yet taken on a professional character. Although there are groups of workers who describe themselves as bioethicists, they do not monopolize institutionalized positions. IRBs and their secretariats involve people from a variety of backgrounds (De Vries and Forsberg, 2002).

Addressing a conference of American nurses in the early 1950s, Hughes (1971: 311) identified what happens when work gets organized into a profession:

People have long nursed the sick, helped the poor and the unhappy, taught the young and looked after collections of books. But the professions of nursing, social work, school teaching and librarianship are all new. They are among the many ancient arts that are now being turned into professions. There are certain symptoms to be seen wherever this happens. The people in the occupation get somewhat self-conscious about many things concerning their work; jealous of their name and badge...; dreadfully afraid that some of their number will not observe company manners and so will hurt the reputation of all; not quite sure what their jobs are or ought to be and consequently not certain what their training should be.

In pursuit of professional status, groups of workers organize, evict their less reputable fellows and create restrictive covenants that control entry to their neighborhood.

A profession is an occupation that has secured legal recognition for these covenants, creating a particular kind of ecological niche, a market shelter that gives its members a privileged position in the market. Potential competitors are excluded or competitively disadvantaged. This way of thinking about occupations, associated with the early writings of Freidson (1970a, 1970b), Johnson (1972) and Larson (1977), represents professions as cartels. Professionals achieved their monopolies by organizing more effectively than consumers and then capturing legislatures to obtain favorable regulation. This would only be checked where there were powerful opposing interests. Larson, for example, contrasts the relative autonomy of US physicians, dealing mainly with individual clients, and the subservience of engineers, dealing mainly with corporate clients. This is a *demand* theory of professionalization: the state yields legal and economic privileges in response to *demands* from an organized group.

In the case of bioethics, a demand analysis would expect to find that the rise of institutional structures for the bioethical regulation of science and medicine resulted mainly from the activity of organized social interests outside of the state. Once in place, these structures might then become the base for further jurisdictional expansion as at least some employees sought, possibly in the name of quality and public service, to close the recruitment to their ranks, limiting it to those individuals who met the educational, social and cultural credentials for a license to practice. This jurisdictional expansion, or professional project, would entrench the material interests of its promoters, guaranteeing them both economic and social rewards in the form of income, power and prestige – in this case, the ability to shape major social and economic interests in the science-medicine-industry complex.

In recent years, however, this understanding of professions has been reconsidered. Demand approaches have been unable to explain why so few would-be professions actually achieve that status. At any historical moment, far more occupations are seeking this privilege than are obtaining it. Both Freidson (1986, 2001) and Johnson (1995) modified their views and a new approach has developed around a *supply* theory of professionalization (Dingwall and Fenn, 1987; Dingwall, 1995, 1999). The supply theory puts more emphasis on the independent role of the state. The legal intervention which sustains the market privilege of professionals is granted only when there is a *coincidence* with a state purpose. The supply approach

acknowledges the importance of expertise and the way in which legal protection may be a *response to* market failure rather than a *form of* market failure. Following the logic of the supply theory, we might expect evidence of the emergence of a professional project among bioethicists, but we would not predict this to result in a licensing regime unless it coincided with some state interest in closing this market. Is such an interest discernible in the processes that have led to the creation of the ethical regulatory bodies that employ so many members of the occupation of bioethicists?

We turn now to look at the specific cases of the emergence and rise of bioethics in the US and France, two countries that have a strong medical profession but different conceptions of the role of the state vis-à-vis its citizens. These two settings allow us to examine how cultural and material interests have shaped the demand for and supply of licensing opportunities and the consequent trajectories of bioethics.

Bioethics in the United States

In the early 1960s there were no bioethicists in the US. There *were* individuals concerned with moral questions raised by medical research and practice, but they were not called bioethicists, nor did they have the institutionalized support of centers for bioethics, professional journals, government commissions, or graduate programs and professorships. Within forty years, bioethics has become an important part of the country's medicine and life sciences. As one of its leaders acknowledges:

Bioethics has to stand as one of the most fascinating and, arguably, important intellectual developments in the last third of the 20th century. I do not say that because it is my field but because it is highly unusual for an intellectual movement to originate as a dream on the part of a few scholars, many on the periphery of the mainstream academy, and wind up 30 years later with programs in major universities granting advanced degrees, its research occupying significant numbers of pages in major journals in many different fields, and its members sitting on national commissions and major professional associations and even popping off in the media (Caplan, 1999).

How did bioethics migrate from the subjective economy and become a recognized part of the official economy in this particular country at this moment in history?

Bioethics as a Jurisdiction

There are two elements to the establishment of bioethics as a discrete occupation: bioethicists must do both the *intellectual* work of defining and claiming ownership of a jurisdiction and the *organizational* work required to secure recognition and legitimacy for that claim.

Intellectual Work—An early challenge for any new occupation is to explain why the division of labor should be modified to accommodate its members. In this case, the occupation needs a story that will justify its migration into the official economy. Whittaker and Olesen (1964) studied the role of 'official histories' in the construction of occupational identities, looking at the ongoing reframing of the biography of Florence Nightingale to legitimize changes in the practice of nursing. Although this occupation was constantly migrating to new kinds of work within the medical division of labor, its identity was sustained by the manipulation of the powerful cultural symbol of Nightingale's heroic work.

There are two salient elements in the "creation myth" of bioethics, both of which make plain the historical necessity of the occupation. The first is scientific progress: America's technological prowess, it is argued, should be matched by a comparable ethical leadership. This can be identified in the founding statements of the first bioethics centers. The Hastings

Center, established in 1969, claims that it was created to “fill the need for sustained, professional investigation of the ethical impact of the biological revolution,” including “advances made in organ transplantation, human experimentation, prenatal diagnosis...the prolongation of human life...” (Hastings Center, 1973; see also, Callahan, 1981).

The second part of the creation story presents bioethics as a response to abuses in clinical practice and medical research, starting with the formulation of the Nuremberg Code in 1947 at the conclusion of the ‘Doctors’ Trial’ for crimes against humanity during World War II (e.g. Jonsen, 1998). In his history of the idea of the Holocaust in the US, Novick (1999) explores how the Holocaust helped to shape Jewish identity at a time in American history when ordinary appeals to the Jewish life and religion were losing their attraction. Repeated references by bioethicists to Nazi abuses in medical research serve a similar function in creating the bioethical identity: a symbol with great potency in the US is evoked to justify the development of the new occupation.

The creation myth of bioethics can be questioned in historical terms. Medicine and science have progressed for at least five hundred years without the benefit of bioethics. Halpern (2004) and Lederer (1995) have pointed to the considerable degree of ethical self-regulation by US researchers prior to World War II (although this did come under pressure from the increasing scale of the scientific community) and Morin (1998) has drawn attention to the developed research governance framework of 1930s Germany. There is not a sharp contrast between a pre-ethical and an ethical world. There is also an embarrassing gap between the end of World War II and the emergence of any demand for bioethics in the US. Rothman (1991) notes that it was not until the late 1950s that US scientists began to notice their questionable treatment of patients and research subjects.²

A more sociological approach would emphasize the legitimization crisis created for US institutions’ by the “rights movements” of the early 1960s (Farrell, 1997; cf. Halpern, 2004). As Dr. Kenneth Ryan, chairman of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (1974-1978), has observed:

Although advances in technology have heightened ethical concerns in recent years, the problems of euthanasia, withholding or withdrawing treatment, truth telling, informed consent, and equitable access to health care have long been with us. *They were just never on an open public agenda* (Ryan, 1986, emphasis added).³

By the end of the 1960s, however, it was no longer acceptable that significant social policy decisions not be on an ‘open public agenda’. This did not, however, mean that such issues were readily resolved. The US had become a highly secularized society without an external and widely-shared foundation for ethical decision-making, so that moral dilemmas, once solvable by reference to a faith tradition, required non-religious solutions. These solutions would also need to reflect the deeply entrenched individualism of US culture (e.g. deTocqueville, 1969 [1835]; Riesman, 1962; Bellah et al., 1985), and the cultural pluralism that – as a result of the rights movements of the 1960s and 1970s – required ethical guidance to be in line with specific features of people and their contexts.⁴

²Rothman describes the publication of the well-known paper by Beecher (1966), exposing questionable practices in human experimentation, followed by further scandals about the mistreatment of human subjects - the Tuskegee syphilis study (Jones 1981), the Jewish Chronic Disease Study and the Willowbrook State School Study.

³One might also argue that demographic shifts in America have produced questions at the “edges of life” (Ramsey 1978, see also Callahan 1987, 1990). Both the “graying” of America and delayed childbearing by baby boomers create large interest groups that must face ethical choices about life support and medical intervention that were uncommon a generation ago.

⁴With the Bush administration’s creation of the President’s Council on Bioethics, there has been a more conservative turn in bioethics, but even here pluralism and individualism restrain the use a single faith tradition as a moral guide.

The best known bioethics text, *The Principles of Bioethics* (Beauchamp and Childress, first edition, 1979; fifth edition, 2001), supplies a checklist of essential principles to perform just such a role: *autonomy, non-maleficence, beneficence, and justice*. Although academic critics argue that this principlist approach does not sufficiently respect the diversity of society⁵, its success suggests that the emphasis on autonomy (Wolpe, 1998) fits well with the “spirit of the times.”

For bioethics to function as a solution to the legitimization crisis, however, it also needs to produce its *own* legitimacy, independent of the factors generating the crisis that it purports to resolve. It is here that the official narrative becomes relevant – not as a rival historical account but as an invocation of transcendent symbols in US culture that support the bioethical claim of jurisdiction just as the relationships of trust between science, medicine and society are being questioned.

Organizational Work—Intellectual work may define a niche but it is not, on its own, sufficient to colonize it. Bioethicists’ struggle to find a collectively acceptable way of organizing themselves has, however, been more challenging than the creation of an intellectual framework. Under US conditions, the legitimate colonization of a niche is subject to powerful isomorphic pressures (DiMaggio and Powell, 1991) to conform to established models of credentialing. This involves the creation of training programs, occupational associations, graduate programs, journals and the like. This is a particular feature of the health sector, which has long been marked by a dynamic of specialization (Bucher and Strauss, 1961). Thomas May, an ethicist at the Memorial Medical Center in Springfield, Illinois, explains:

If you’re a cardiologist, and a foot problem arises, you may call in a consultant in that particular specialty to help identify the problem. [Similarly, moral quandaries beyond the grasp of doctors] will seem obvious to a philosopher, because, you see, we deal with these concepts every day (quoted in Shalit, 1997: 24).

Bioethicists need to conform to this model to secure their particular jurisdiction within the medical division of labor.

Isomorphic pressures are particularly evident in the mandated sites for bioethical activity, like hospital ethics committees and Institutional Review Boards (IRBs), which review and approve research involving human subjects. Hospital accreditation in the US requires institutions to have an ethics committee, normally made up of various health and social work professionals, local clergy, community members, and administrators. In the late 1990s the credentials of ethics committee members were debated on the “biomed-I listserv” (biomed-I@listserv.nodak.edu). This debate reflects the ambivalence about professionalization among bioethicists at that time. It began with a simple question:

...do...any member [s] of the [hospital ethics] committee need to be licensed/certified?

Responses varied. Some were suspicious of licensing:

...licenses...restrict more than they liberate...Most licenses don’t recognize alternative means of securing competency and that a number of professionals and indeed non-professionals can contribute to the ethics committee...

Others found licensure to be a useful tool:

I would recommend some form of credentialing for the committee chairmen.
Otherwise there will be risks of the committee decisions being railroaded by someone

⁵See Pellegrino, 1993, for a “30-year retrospective” on the theories of medical ethics.

with the gift of persuasion but with less than complete understanding of ethical principles...

Licensing would add to the credibility of individuals and be an indication of the commitment to the issue.

Still others reflected on the problem of credentialing in bioethics:

One of the main arguments against [licensing and credentialing] is that the educational background, occupation and experience of all those who participate in bioethical facilitation [are] so varied that there might be no unified basis for judging the... competency of any candidate...[E]thical decision making is a function that anyone could perform and the opinion of a lay person might be just as significant as that of a philosopher.

There has been a similar discussion about the credentialing of IRBs and IRB members: in its report, *Ethical and Policy Issues in Research Involving Human Participants*, the National Bioethics Advisory Council recommended that “all investigators, Institutional Review Board members, and Institutional Review Board staff should be certified prior to conducting or reviewing research involving human participants” (2001: 48-49).⁶

If these sites can be turned into market shelters, either by monopolizing them for bioethicists or by installing bioethicists as gatekeepers, then they may become a basis for occupational closure. However, bioethics evolved as a diverse, interdisciplinary movement and has struggled to form a unified occupational association, let alone to agree occupational standards and define a unique body of knowledge. Until late 1997 there were four major bodies: the *American Society of Law, Medicine, and Ethics* (ASLME) -- representing those with a special interest in law and medicine; *The Society for Health and Human Values* (SHHV) -- an interdisciplinary group of social workers, pastors, philosophers, clinicians, artists, lawyers, and other humanists; *The Society for Bioethics Consultation* (SBC) -- representing clinical bioethicists; and the *American Association of Bioethics* (AAB) -- representing academic bioethics. During the late 1990s these organizations held joint annual meetings, promoting interaction among their members, and paving the way for a merger of some sort.

The debates over a possible merger revealed the tension between those who championed the field's interdisciplinary character and those who wanted to establish a specialized profession. When the AAB was officially launched in 1993 -- an organization “devoted solely to the advancement of the field of bioethics (AAB, n.d.) -- sister organizations were invited to take a seat on the newly formed board. SHHV declined: then-president Joel Frader (a sociologically trained M.D.) explained this decision:

I have found some of the interactions around the birth of the AAB confusing and disappointing. In contrast to the inclusive spirit of the SHHV, which attracted me in the mid-to-late 1970s, an entirely different atmosphere seemed to surround many AAB dealings. I sometimes perceived, perhaps wrongly, contempt and disdain for those, like myself, without “proper” credentials (Frader, 1993).

Nevertheless, after inter-organizational negotiation, the advocates of merger won a vote to merge the SBC, SHHV, and AAB at the joint meeting in November 1997, and the *American Society for Bioethics and Humanities* (ASBH) was formed.

⁶At present there is a private organization that offers IRB accreditation: the Association for the Accreditation of Human Research Protection Programs Inc., (<http://www.aahrpp.org/www.aspx>); and an organization that certifies IRB professionals: The Council for the Certification of IRB professionals (<http://www.primr.org/certification/certification.html>). A third accrediting body, the Partnership for Human Research Protection, Inc. (PHRP), dissolved on 15 November 2005.

The next task for the professionalizers is to find a way to “separate the sheep from the goats, to set up categories of truly professional and of less-than-professional” (Hughes, 1958: 133-135). This is an ongoing problem, complicated by the fact that the best-known bioethicists do not have professional training in the field. Those who founded bioethics come from a variety of backgrounds, including philosophy, medicine, theology, social science, nursing, and law. When interviewed (by RdV) in 1992, many of this generation insisted that the proper career route was to first get an advanced degree in one of these fields and only then to come into bioethics. They asserted that this was a rich, interdisciplinary field that drew some of its best insights from the conversation between disciplines and that a narrower and more focused training would diminish the field.

By 1997, these attitudes were changing. The demand for an occupational identity led many bioethicists to rethink their stance and establish university-based graduate programs in bioethics.⁷ Their creators have struggled to explain how specialized training can co-exist with the dogma of an interdisciplinary field. Arthur Caplan, director of the University of Pennsylvania Center for Bioethics, commented on their new M. Bioethics (Masters in Bioethics) program:

Among all of my colleagues I have been the most vociferous critic of starting an advanced degree program in bioethics...I have long been suspicious of bioethics degree programs because I fear they may lure people to enroll in the false belief that holding an MA degree in bioethics will produce a job as a bioethicist. But my fears... have been allayed by the agreement...that the students Penn will seek to attract will either have an advanced degree in hand, will be pursuing one simultaneously...or will fully understand the need to continue their professional studies beyond the M.Bioethics (Caplan, 1997).

Masters programs – residential, night and weekends, and distance learning – have become ubiquitous, and Ph. D. programs are appearing. Specialized degree programs are a step toward sorting out who can and cannot claim to be a bioethicist.

With the creation of a merged professional organization and the rise of credentialing, it is easier to separate the “sheep from the goats,” the “truly professional from the less-than-professional”. Nevertheless, the professionalization agenda remains contested within the field. In 1998, ASBH adopted the report of the Task Force on Standards for Bioethics Consultation, which took a strong stand *against* certification on grounds including: 1) a fear that certification would increase the risk of displacing providers and patients as the primary moral decision makers, and 2) concern that certification could undermine the disciplinary diversity of bioethics (see American Society for Bioethics and Humanities, 1998; Aulisio et al., 2000). In the absence of unity, it is hard to see how the occupation could push forward in a context where further development is likely to elicit increasingly powerful opposition.

Contesting Jurisdiction

Bioethicists may have developed intellectual and organizational strategies to support their demand for jurisdictional recognition. This does not, however, guarantee that their claims will be recognized. The division of labor in health care continues to be dominated by the medical profession (Dingwall, 2006). The creation of a bioethicist jurisdiction based on authority over moral issues will encroach on the established jurisdictions of physicians and other professional groups. It may be impractical for non-specialists to keep up with the bioethics literature. A well-developed specialty could limit physician authority to the technical aspects of medical care. Moral authority lies so close to the heart of medical jurisdiction, however, that it is hard

⁷Visit <http://programs.gradschools.com/usa/bioethics.html> / for a listing of programs offering advanced degrees in bioethics.

to see this being ceded, much as the physician may appreciate the help of an adviser who can reframe professional decisions in a politically correct fashion or help to manage troublesome patients or relatives.

Furthermore, the value of a moral adviser is limited by the different balance between action and reflection within the occupational cultures of physicians and bioethicists: notoriously, physicians act and bioethicists reflect. As Jonsen, a bioethicist, remarks:

I am...satisfied that most of "our crowd" [i.e., bioethicists] dwell in the world of intellectual ambiguity and are convinced that solutions must find their way among the least worst options (Jonsen, 1996: 5).

When these cultures collide, contemplation and ambiguity lose out to the frequent requirement for decisive action in clinical situations.

The deference to medical authority implied by this subordinate jurisdiction has not gone unnoticed. In an article marking his retirement as president of the Hastings Center, Daniel Callahan (1996: 3) expresses his fear about the role of bioethics:

In the early days... there was an interesting debate between the views of Joseph Fletcher -- who never said no -- and those of Paul Ramsey -- who usually said no and who argued that the capacity to do so was a test of moral seriousness. It appears that Fletcher won the day. While bioethics creates problems now and then for the mainstream, right-thinking trends, it mainly serves to legitimate them, adding the imprimatur of ethical expertise to what somebody or other wants to do.

A younger generation worries publicly about whether they are "watchdogs," "lapdogs," or "showdogs" (Elliott, 2001). In answer to her question, "...just whom...[are] the ethicists really serving?", Shalit (1997: 25) asserts that:

A swelling corps of HMO utilitarians are cashing in on their ethical expertise, marketing their services to managed care executives eager to dress up cost-cutting decisions in Latinate labels and lofty principles.

The role of a clinical bioethicist resembles that of a public defender in the American legal system. The formal role of each is to represent the interests of a client in a large and confusing organization, but both must also maintain good relationships with other members of that organization, many of whom are working against their clients. Given this situation, both are inclined to represent the interests of professionals and institutions over those who are merely passing through -- patients and families (cf. Feeley, 1979).

If US bioethicists are not the watchdogs they had hoped to be, what are they doing? Their work is often associated with messy emotional, relationship, or spiritual/religious issues: Bosk (1992), for example, describes genetic counselors as a "mop-up service" -- a way for physicians to delegate the awkward task of dealing with distraught parents. Andre (1998) offers a similar view in describing a week in her work as a clinical ethicist. This began with a typical case: a physician, faced with conflict over a feeding tube for an elderly woman, requested an "ethics" consult:

Everything about the situation was familiar; the issue (refusal of treatment); the procedure (we listened, we talked, we asked about how [the patient] had lived her life and what she said she had wanted); and the resolution (a patient or her surrogate has a right to refuse treatment, even when refusal risks shortening her life)... We listened with attention and respect... [we] reminded [the patient's daughter] that she was free to change doctors.

Reflecting on the results, Andre concludes:

Consultations are a slow and expensive process. [The patient's] life was probably shortened slightly... [The] daughter felt far better: perhaps that was the major positive result. The physician probably felt more comfortable too.

Andre wonders why she was called in. Was the doctor genuinely uncertain about the right thing to do or just looking for legal protection?

Clinical bioethicists in the US seem to be doing a form of social work or dispute resolution: listening to patients (or staff), suggesting options, finding ways to reconcile individual and institutional agendas. Picking up some of the "dirty work" (Hughes, 1994) of medicine does not seem a convincing basis for the construction of anything more than yet another subordinate profession in the medically-dominated division of labor. As we see below, bioethics in France has followed a very different course.

Bioethics in France

Despite sharing an intellectual history with the US, France has followed its own path in relation to bioethics. In doing so, it underlines the contingency of the processes of occupational development in the US. There is evident reluctance on the part of the French state and medical profession to acknowledge any jurisdictional vacancy for a specific occupation of bioethicists. Indeed, the very idea is often ridiculed and there is no recognized term for such a person in French, at least in France (other francophone countries have adopted *éthicien*). No one is doing the intellectual or organizational work to promote such a development. The Cordier Commission (Commission Cordier, 2003)⁸ on "Ethics and health professions" rejected the 'American model of professional ethicists' and proposed an alternative model of "référénts" in medical ethics. These referents would be people already involved in healthcare with additional training in ethics. Those who are not licensed physicians (such as a historian of medicine or a scientific researcher) would first need to acquire a Ph.D. demonstrating specific expertise in both medicine and ethics.⁹ The National Consultative Council on Ethics (CCNE)¹⁰ endorsed this position.

Clinical Ethics in France

Under isomorphic pressure to conform to the ethical standards introduced by major Anglo-Saxon scientific journals, review boards (CCPPRB¹¹) similar to IRBs were set up by the *Loi Huriet* in 1988, but "patient's rights" did not appear as a legal term until 1991 (*Loi Evvin*). This does not mean that France has been wholly indifferent to the rights of patients. The Code de Déontologie Médicale was revised in 1995 to give greater weight to informing patients and allowing them access to their records. This was reflected in the publication of a "Hospital Patients' Charter" and a judgment by the highest appeal court, the Cour de Cassation, in 1997 that required physicians to prove they had given patients all the information they needed to consent to a procedure. This has subsequently been confirmed by changes to the Civil Code (article 16-3) and a recent law on Patients Rights (2002)¹².

Despite these developments, decision making, especially at the end of life, still remains in the physician's hands (Ferrand, 1996; Ferrand et al., 2001; Pochard et al., 2001; Orfali, 2004). The "therapeutic justification" (art.35 of the Code de Déontologie) allows physicians to continue restricting information in some cases. Even the recent End of Life Law (2004) leaves substantial

⁸The Cordier Commission was mandated by the CCNE to work on its specific report on "Training in medical ethics."

⁹This does not mean that there are no academic diplomas in healthcare ethics. Diplomas are available from several centers such as Centre d'Ethique de Lille or Laboratoire d'Éthique Médicale et Biologique de la Faculté de Médecine Necker-Enfants Malades.

¹⁰Avis n°84 sur la formation à l'éthique médicale

¹¹CCPPRB : comités consultatifs de protection des personnes dans la recherche biomédicale

¹²Law n°2002-2003 of March 3 2002 on the Patients Rights and the Quality of the Healthcare system.

discretionary power to physicians;¹³ while informed in 59.1 per cent of the cases, only 17 per cent of families had a role in decision making at the end of life (Pochard et al., 2001). In neonatal care parents are explicitly excluded from decision-making because they are considered too emotional: the decision to continue or to withdraw care “should remain a strictly medical decision” (Dehan, 1997). Informed consent does not imply patient autonomy and decision-making.¹⁴

Attention to clinical ethical issues has increased within hospitals and the medical profession. There is evidence of some reconfiguration of power structures and a search for new modes of legitimization. Ethics committees and informal groups – initially composed mainly of physicians but now incorporating other caregivers – have appeared spontaneously in most university hospitals. Most of these groups work on ethical issues in hospital life, such as preserving the patient’s dignity and confidentiality, the needs of residents regarding pain management etc. They serve mainly as informal platforms for discussion and do not really offer *ethics* consultation services. In 1995 the largest French public hospital network (APHP)¹⁵ created a more formal “Espace Ethique” to deal with intra-professional discussions about bedside ethics and to develop training to increase ethical awareness among caregivers. Most students in medicine or other healthcare professions are more or less trained in “ethical” matters by physicians and, to a lesser degree, by philosophers. Moral philosophy is playing an increasing role in ethics teaching (Lecourt, 2000): asked in a survey to define “expertise in ethics”, most French healthcare givers saw this as an education in philosophy (Mino, 1999).

Ethical oversight in France remains in the hands of the medical establishment (Mino, 1999), especially in the clinical setting, leading more to the self-regulation of experts than to any external control. In a way, a focus on ethics has led to preserving professional medical power by *internalizing*, and thereby disarming, a critique. Ethics gets absorbed within the medical profession instead of allowing lay interventions into the medical world. Teaching medical ethics to French physicians essentially means increasing their own professional moral awareness¹⁶, provoking reflexivity in specific cases. There is no obligation, however, for caregivers to enroll in ethics courses or to abide by any HIPAA-type or “good clinical practice” training. This is a matter of professional conscience rather than external regulation.

French bioethics has not challenged scientific and medical authority in the name of accountability in the manner of its US counterpart. From Claude Bernard’s (1927 [1865]) assertion of the autonomy of science more than a century ago (the researcher’s accountability is “only to stand face to face with nature”)¹⁷ to the present accountability of physicians to their peers, professional medical authority is unquestioned. These same peers are the ones who shape norms through recommendations in the CCNE, through self regulation in professional organizations (such as Néonatalogistes, Intensivists etc.) or in end of life decisions (Orfali, 2001), ART policies (Memmi, 2003; Novaes, 1995) or medical practices at the bedside in the hospitals. They design health policy (Orfali, 2001, 2002) and set constraints within which the government and the Assembly operate.

Despite their continuing professional autonomy and discretionary power, hospital physicians do give considerable attention to the ethical justification of their practices as serving both individual patients and the common good. This has brought about a greater degree of collegiality¹⁸ and peer debate about what is socially and morally acceptable. But the

¹³But this power is nowadays compelled to be collegial regarding end of life decisions.

¹⁴It is the “therapeutic necessity which justifies any intervention on the bodily integrity – not the consent” (Rameix 1998)

¹⁵APHP: Assistance Publique des Hôpitaux de Paris.

¹⁶« une formation éthique doit comporter(...) l’éveil des dispositions au questionnement devant les cas particuliers.. »

¹⁷An Introduction to the Study of Experimental Medicine, 1865, 1st Translation in English, published by MacMillan & Co.Ltd 1927, p. 221.

uncertainty of ethical dilemmas is converted into objective medical certainty (Orfali, 2004). The profession's collective response to uncertainty, emphasizing the issues of dignity and societal well being, is taken to demonstrate the ethical responsibility required by the State. By demonstrating that they act both responsibly and virtuously, the public medical experts can argue that they are acting without self interest in the pursuit of a patient's welfare, which necessarily coincides with societal welfare. Their accountability is not towards individual patients or their families, but towards society as a whole; ethical rhetoric unites these sometimes conflicting interests into a unique medical responsibility towards the State, viewed as the benevolent guardian of society. While the French State asserts a right to intervene to protect individuals, it has appointed professionals to act on its behalf: physicians at the clinical level, and the CCNE at the level of society.

Intra-professional norms defend a case by case approach to clinical decision-making rather than relying on regulation that may lack flexibility in its application. Despite many scandals within the public sphere - contaminated blood, the use of growth hormone - trust in public experts, endowed with the virtue of universal authority and ethical competence, remains surprisingly high in France. The professional autonomy of medicine has hardly been eroded: initially responsible for determining the strictly pathological, physicians are now in the position of also defining what is ethical (Orfali, 2001). There is no occupational vacancy for bioethicists in an ecology where physicians are secure in both a moral and a technical jurisdiction. "Bioethics à la française", in the words of N. Lenoir (1991), a former Minister, has produced institutional oversight over research and, to some extent, medical practice, but the legal framework still leaves physicians with much discretionary power.

Bioethics as a universalistic 'Grand Projet'

Although France lacks bioethicists, it does not lack bioethical debate – but this takes place in politics and the media rather than in clinical settings (Orfali, 2002). France created the first national consultative council on ethics (CCNE) in 1983. Its mission was defined as: "to give advice on the moral problems which are raised by research in biology, medicine and in the field of health; problems which concern mankind, social groups and society as a whole". While there was discussion in 1994 about extending the CCNE's role into clinical practice, the idea was never adopted, on the grounds that this function was already part of the jurisdiction of the "Ordre des Médecins"¹⁹.

The 1994 "Bioethics Laws" specified the status of the human body as something that could not be commodified. Borrowing from Rousseau, the individual body is seen "as a member of the social body"; and "individuals are more holding their own body as usufructuaries rather as owners."²⁰ Consequently, the principle of *dignity* prevails over autonomy.²¹ Dignity is threatened when technology "makes everything even the non-ethical possible": there is a public responsibility to prevent such abuse. The preservation of 'dignity' is in the hands of the State and its institutions such as the CCNE. Despite its advisory role, the CCNE has powerful moral authority²² as the "guardian institution of Bioethics" (Memmi, 2003: 46); it was, for instance, the most quoted source in the Assembly debates on the 1994 legislation. CCNE members are mostly physicians or research scientists selected by the government: 64 per cent of the committee in the years from 1983 to 1993. Almost all are public servants with effectively no representation from the private sector or the lay world. Ethical competence in France is

¹⁸By law this collegiality is required now for end of life decisions in the hospitals.

¹⁹All the physicians in France are required to register with the Ordre des Médecins, the French equivalent of a kind of AMA, created under the Vichy government to control access to the profession and maintain a professional deontology.

²⁰"(...) le corps individuel est conçu davantage comme membre du corps social et les individus en sont davantage les usufructuaires que les propriétaires », D.Memmi p63, translated by us.

²¹Rapport of Conseil d'Etat(1998).

²²« The only power of our committee is a moral power...Laws should be as few as possible », Jean Bernard, Le Monde, 12/6/ 1984

embedded within medical and scientific expertise, allied to what Bourdieu calls “State Nobility”²³, mainly high ranking civil servants. Expertise has a status of universality and “objective truth”, especially when, as with science and medicine, it can claim to serve the public good, as if explicitly mandated by the State²⁴ and by society. The authority of knowledge enlightens the political authority of the State. Experts debate issues in private, producing reports authored by experts, on the basis of interrogating other experts on topics such as “Opinion on training in medical ethics” or “Technical Progress, health and model of society”²⁵.

Ethical issues in France, then, are not an ‘open, public agenda’ as in the US. The recent “*Affaire Humbert*”²⁶ exemplifies this. Although the media claimed that this had led to the 2004 End of Life Law, this was actually based on the work of a committee in which only experts (mostly doctors and a few philosophers) were heard. Marie Humbert, the mother, whose role was widely praised in Parliament, was not even interviewed. Civil society’s voice remains weak if not absent from such debates.²⁷

France may be characterized by a strong institutionalization of bioethics but it is, in effect, a “*Grand Projet*,” a universalistic enterprise, a striking symbol of a French cultural model that is only loosely connected to the world of practice. As a nation, France has, like the US, traditionally identified itself as having a privileged mission towards humanity, consequent on the assertion of universal values such as liberty, equality or human rights. It is not surprising, then, that universal rhetoric of bioethics has been preferred to a more applied, clinical approach. French bioethics deals with overwhelming questions like the impact of science, technology and medicine on the human being and the future of humanity. These discussions prioritize repertoires of universality such as the future of humankind but do not offer a space for the mundane bedside concerns of the US clinical ethicist. While the status of the embryo or the medical advances regarding the potential of assisted reproductive technologies (ART) are debated at length by experts in medicine (Novaes, 1995; Memmi, 2003), science and, to a lesser degree, philosophy,²⁸ issues around end of life decision-making, neonatal care or incompetent patients get hardly any attention.

The French path has led to a separation between clinical ethics and bioethics. The former remains strongly controlled at the local level by physicians and health institutions; the second, at a more macro level, relies on a ‘government of experts’ from the medical, scientific and governmental spheres. Both fields remain under heavy public medical jurisdiction, and contribute little to challenging the professional autonomy of medicine. There are no professional ethicists in France; all medical and scientific experts, by virtue of their legitimate expertise, are implicitly endowed with ethical competence. Professional ethics is preserved within this realm rather than separated from medicine. As mentioned by the CCNE²⁹ the “field of ethics does reveal itself through the emergence of questions articulated around the central notions of deontology. Dilemmas between respect for life and taking into account quality of life issues”... (2004: 11). In that sense, clinical ethics is seen as emerging around questions unanswered by deontology but in relation to it.

²³Noblesse d’Etat, Bourdieu, Bourdieu (1989)

²⁴The strong position of the hospital physician unions in France is all the more remarkable given that it is in no way founded in law.

²⁵Avis n°84, 2004 and Avis n°57, 1998 of the CCNE.

²⁶In 2004, the Humbert case involved the mother and the physician of a young boy, severely handicapped after a car accident, who had repeatedly asked to die. The patient had tried to draw the attention of the media and the politicians by writing an open letter to the French President. With help of his mother and the hospital physician he finally died.

²⁷During the Parliament debate in Nov.2004, not one politician ever mentioned the word « autonomy » regarding the patient.

²⁸Between 1983 and 1993, more than one third of the CCNE’s recommendations were on ART or the embryo, another third were on issues related to research on human being and the last third was on genetics.

²⁹Report on “Training in medical ethics”,

Despite being so deeply embedded in the medical world, the CCNE has nevertheless fostered changes in social practices and their legitimation by promoting the ideal of self control as the basis of ethical regulation. By appealing to self control³⁰ from patients, physicians or judges, the CCNE aims at avoiding the pitfalls of rigid rules or laws. Everyone should internalize the accepted principles so that there is no need for external oversight. The success of this strategy is marked by the rarity of litigation compared to the U.S. or even debate on clinical ethics. The strong collusion in France between the State and the medical profession around health policy, medical ethics and bioethics creates an alternative cultural model of bioethics. The conversion of patient autonomy into human dignity, a concept that has been exported to other European countries,³¹ suggests that France has, at least in part, succeeded in its self appointed universalistic mission.

Conclusion

This decentred comparative analysis enables us to better understand the contingent nature of professionalization, which is often discussed through narrow case studies of specific occupations in specific countries at specific times. The demand model is only sustainable within such a tight focus, which concentrates on the activities of the successful interest groups. Bioethicists have made limited progress in professionalizing in the US partly because they are unable to agree among themselves what their occupational model should look like. Nevertheless, to the extent that they have moved along this path, it reflects their location within a society and a medical division of labor that offers space for such enterprises, and social and cultural conditions that favor the intellectual and organizational work involved. US bioethicists have been quite successful in selling the idea that ethical health care requires moral as well as technical specialists. As the French experience shows, however, this case could only be made in a social environment that perceived a crisis in ethics that could only be solved by these means. In the space available here, it is not possible to go deeply into the sources and nature of that crisis. We can, though, reasonably argue that more attention needs to be given to understanding the problem to which professionalized bioethics is considered to be the solution. This is a more complex task than purely a matter of state interest, as early versions of the supply model have tended to suggest, not least because of the decentralized nature of the American state.

At the same time, the French experience reminds us that there are alternatives. Professionalized bioethics is not historically inevitable. This is an important lesson, because US cultural and economic hegemony often tends to press others to adopt institutional models that are ill-suited to their own national environments. Even the French have been compelled to introduce IRB-like regulation of clinical and scientific research, although this does not yet extend to the social sciences. It is far from clear that the emphasis of US bioethics on autonomy is appropriate in European social and Christian democracies, where the values of community and civic solidarity are given much greater weight, particularly in health care. The situation in France presents a competing model, in comparably universalist terms, that stresses the ethic of care and professional responsibility rather than encouraging a simple rights-based approach to ethical questions. Clearly, the French model has its critics: like many French institutions it creates a powerful elite who are only weakly accountable for their actions. At the same time, it does insist on the moral obligations of that elite rather than subcontracting professional conscience to a group of economic dependents who are unlikely seriously to challenge their sponsors.

³⁰ « Self-controls have increasingly become both the focus and the locus of social controls », C. Wouters 1999.

³¹ Notable in many international treaties such as the " Convention Européenne sur les droits de l'Homme et la biomedicine " in 1997 or the multiple texts of UNESCO.

Comparative analysis reminds us of the choices that can be made: it is not self-evident that high ethical standards in health care are necessarily achieved by creating a new profession of bioethicists rather than seeking to use existing regulatory means to encourage the ethical sensibility of existing professionals.

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