To the Graduate Council:

I am submitting herewith a dissertation written by Pamela June Grace entitled "A Philosophical Analysis of the Concept 'Advocacy': Implications for Provider-Patient Relationships." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Philosophy.

Glenn C. Graber, Major Professor

We have read this dissertation
and recommend its acceptance:

James L. Nelson

Martha R. Holmes

Betsy Postow

Accepted for the council:

Associate Vice Chancellor and
Dean of The Graduate School

A PHILOSOPHICAL ANALYSIS OF THE CONCEPT 'ADVOCACY': IMPLICATIONS FOR PROFESSIONAL-PATIENT RELATIONSHIPS

A Dissertation
Presented for the
Doctor of Philosophy
Degree
The University of Tennessee, Knoxville

Pamela June Grace
August 1998

ACKNOWLEDGEMENTS

I have received support, encouragement and assistance with this endeavor from a variety of sources. I wish to thank the faculty, and fellow graduate students of the Department of Philosophy for willingly sharing their expertise and for their intellectual challenges. I am especially grateful to Glenn Graber my dissertation director for his thoughtfulness, valuable comments, and continuing encouragement during the development of this project. My thanks go also to committee members; Jim Nelson, Betsy Postow, and Martha Alligood for their insightful comments and suggestions. Additionally, I would like to thank Richard Aquila who has been an ongoing source of information, encouragement and assistance. I have received kindness and assistance from Marie Horton and Anne Beardsley in negotiating technical hazards.

During the course of my Doctoral studies I have also benefited from the warm encouragement of my faculty colleagues in the College of Nursing; they have been instrumental in my success. I wish to thank my American 'family' of friends for having faith in me; particular thanks go to Nan and Mark Gaylord, Pat Droppleman, Bill and Callie Hale, and Jenny Heyl for their steadfast encouragement of my progress. Finally, I would like to thank my family for believing that I could do this.

ABSTRACT

This project provides an analysis of the concept 'advocacy'. It uncovers assumptions regarding the meanings of advocacy as this concept has been utilized in health care settings to describe professional actions of various sorts. The primary objective of the undertaking is to facilitate the goals of medicine, nursing, and other health care professions in regard to the population of their concern. To the extent the goals of medicine and nursing are focused on promoting the well-being of persons and society the pursuit of such goals is a moral endeavor. The analysis provides for consistency of communication among the professions with regard to advocacy and exposes the scope of professional obligation for health care professionals.

Chapter One outlines problems surrounding uses of the term 'advocacy.' It offers an explication of other concepts which prove important for the analysis such as 'profession', 'physician-patient relationship', 'nurse-patient relationship', and 'clinical ethics'. Chapter Two makes some distinctions regarding advocacy and considers the context in which professions provide service to society. Additionally, the 'ideal' of lawyers as exemplars of professional advocacy is explored since it is from this setting notions of 'advocacy' for health care professions have been borrowed.

In Chapter Three an investigation of the nature and

foundations of professional obligations is undertaken. Codes of ethics are discovered to be important sources of a profession's own view of its obligations; these allow assessment of a professional's moral accountability. As the investigation develops, professional advocacy is seen to be a complex role-responsibility. The focus of Chapter Four is a discussion of the proposal that professional advocacy is a broader concept for health care professionals than it is for legal advocates because it involves both attention to individual needs and attention to the needs of society. Thus the source of some interdisciplinary confusions is located.

Finally, Chapter Five elucidates the implications of the newly clarified concept 'Professional Advocacy' when this is applied to health care situations as an account of health care professional obligation to both individuals and society.

TABLE OF CONTENTS

CHAPTER ONE

ADVOCACY ARCHITECTURE

INTRODUCTION

Disputes

Various health care and allied professionals have assumed that they need to be, can be, or are advocates for those in need of health care services. No consensus, however, exists among the diverse interested groups, or even in some cases within disciplines, regarding what it means to advocate for a person who either has or may develop a need to access the health care system.

Additionally, certain disciplines have claimed that their practitioners are the best situated to advocate for patients asserting variously that others are constrained by employer or contractor conditions; that others have insufficient contact with individuals to determine their advocacy needs; or that there is limited access of the involved professionals to the sorts of information which would enable advocacy actions. Examples of such accusations are readily found in current professional and scholarly literature (Bernal, 1992; Bishop & Scudder, 1990; Cooper, 1988; May, 1983 and numerous others).

Advocacy Ambiguity

When the contexts of these debates are examined it may be noted that the term 'advocacy' is used in a variety of ways and to support a plethora of claims. This very ambiguity regarding the meaning of the term and, consequently, its related obligations, presents a risk that the focus of enquiry may be shifted by these noisy but sometimes superficial battles away from more crucial questions regarding how and why the need for advocacy, regardless of definition, arises. That is, it may not be recognized that a preliminary requisite to the debate about advocacy is an analysis of underlying assumptions regarding the various uses of the term when it is applied descriptively or prescriptively to relationships in health care settings.

Moreover, by engendering argument and turf battles, claims which assert the superior advocacy ability of one professional group over that of others may prove counterproductive to individual, group or societal welfare. Such claims may do so for the simple reason that to be found among the most powerful or vociferous debaters may be those who do not possess the most morally defensible arguments, the best understanding of the issues, or the strongest impetus to tackle the problem at a fundamental level.

Conceptual confusions of this nature tend to be divisive. They place an artificial wedge between professions

which, while they may have different approaches to the furtherance of this, nevertheless, have a similar end or goal. The purpose of this concept analysis is twofold; 1) to provide for some agreement and consistency of communication among disciplines regarding advocacy, and 2) to examine the assumptions underlying the notion of advocacy as this is used in relation to certain health care professions.

The Project Structure

The objective of this project, then, is to explore the concept 'advocacy'. In so doing the ground of the moral obligations of health care professionals is clarified. This ground concerns furtherance of the welfare of others; it specifically concerns the welfare of those who either have health care needs or may develop a need of this sort. The main focus of the endeavor involves an analysis of the concept advocacy particularly as this relates to health care professional role. However, since 'advocacy' is found to have been borrowed from its origins in law, it proves necessary to compare its meaning in this context with its usage in other contexts.

In the remainder of Chapter One, I outline the development of my argument before laying some preparatory foundations for the ensuing discussion. A sample of problems that arise as a result of conceptual confusions regarding 'advocacy' is offered as supporting evidence of the need for

such an endeavor. An explication of the terms; 'profession', 'physician-patient relationship', 'nurse-patient relationship', and 'clinical ethics' is done in relation to the association of these notions with that of 'advocacy'.

Chapter Two lays out some preliminary distinctions regarding common employments of the term 'advocacy'. It is discovered that if one examines the idea 'advocacy' from the point of view of the origin of the primary motivation[1] of the agent two main distinctions appear. The differentiation involves the possibility that some advocacy actions are primarily self-centered and others are not. It may not always be possible to conclude objectively for a given agent what her motivation is, nevertheless, I shall show that the alternatives given are plausible and critical to the discussion of advocacy.

Professional advocacy or that which stems from the professional role appears to be a special case of altruistic[2], or not primarily self-centered, advocacy. A preliminary definition of professional advocacy involves the following formulation. Professional advocacy occurs when *a professional possesses specialized knowledge, skills, or*

---

[1]There is, of course, complexity in the gamut of possible motivations. Pertinent factors are discussed in Chapter Two as these prove relevant to the task. The main distinction I want to make is between agent intent to act primarily on behalf of self or primarily on behalf of another.

[2]I give a definition of altruism later.

technological expertise that is brought to bear[3] *to fulfill a good for a given individual who has suffered a privation, or limitation of resources with regard to the good in question, such that the individual is either unable or unwilling for some reason to provide for the good herself.*

For each of the categories of 'advocacy' explored, there are related moral issues; and examples of these are given to illustrate the nature of such problems. The moral content of 'professional advocacy' however, as the principle subject under study is delineated as the main ongoing topic of concern. The second part of Chapter Two considers the context within which professions provide service to society with regard to the 'good' they profess to be capable of addressing.

This involves a discussion of 'justice'; in particular the second section of Chapter Two discusses the link between professional service and the structure of justice for the given society. Professions 'profess' to be capable of providing a service to society with regard a particular good. For this reason it proves enlightening to include a discussion of justice, because justice tells us something important about these goods. The justice arrangements in a given society are instructive regarding what goods the

---

[3]The degree of action undertaken for any particular event may vary from agent to agent for the reason that professionals are also humans and thus subject to varying subjective and objective forces which may compel or constrain action.

society values and is willing to protect individuals and groups in the possession of.

In the USA the justice system involves safeguarding certain rights. Rights are defended by lawyers who act as advocates for their clients. The 'ideal' of lawyers as 'professional advocates' is crucial to the current enterprise because advocacy has its origin in the legal setting. 'Legal advocacy', then, is a form of 'professional advocacy'; it serves throughout this project as a template for comparison with 'professional advocacy' for other disciplines.

Chapter Three is an in depth investigation of the nature and foundations of professional obligations. The intent is to illuminate the link between professional advocacy and professional obligation. The 'Codes of Ethics' of various disciplines represent in some way what the profession expects of its practitioners with regard to professional conduct. The process of 'code' formation for a discipline is discussed because knowledge of this process provides insight into the profession's vision of its accountability to the population served. The second section of Chapter Three is a consideration, and rejection, of the claim made by certain commentators that professionals seem to hold a different moral status than do non-professionals. It addresses the question: "should members of a profession be held to a different standard of moral conduct than other

citizens?" It proved important to take this question seriously because if the notion of some sort of 'universality' is undermined, as occurs when we propose there may be differences in moral status among people, then we are denying the 'ideal' of persons as fundamentally equal individuals in the sense of being worthy of moral concern. I will show that the idea that individuals have moral worth proves important for this project. The reader will find the full argument for this in Chapter Three.

In the absence of special ethical status[4] for professionals, the objective becomes a description of the foundation of the seemingly stronger obligation that exists for them than exists for lay persons to promote the good in question. Since the stronger obligation arises from the fact of the professional's voluntary commitment to the goals of the profession, assumed upon gaining membership to the profession, a further important factor can be noted. This factor consists in a commitment on the part of the profession, and therefore the professional, to the population of concern for the profession. Consequently, there is a close relationship between the goals of the profession and the goals of the society. In the absence of

---

[4]This is special ethical status in a radical sense. For example, it is sometimes claimed that lawyers are not subject to the same moral constraints against harm, as others in the society, at least while advocating for a client. I argue that this conceptualization of the moral aspects of the legal advocacy role is incorrect.

this close relationship or in the absence of a realistic ability to further the 'good' in question the societal usefulness of professions has to be questioned.

Contemporaneously, this is the situation the US finds itself in, with regard to health care and the health care professions. The present system is proving problematic for health care professionals and for society. Such problems require both that professions reevaluate their situation with regard to society, and that they be instrumental in bringing any dissonance in values to the attention of its served population. This proves to be a moral imperative based on the profession's own assertions regarding the scope of its accountability as espoused in the profession's code of conduct.

The next section determines professional advocacy to encompass the professional role. It becomes important to make comparisons between the role of professional advocacy for legal representatives and the role of professional advocacy for health care professionals. Health care professional advocacy is asserted to be broader in scope than legal advocacy since it involves not only advocating for an individual but also advocating for societal change when this is what is required to further the goal of health for an individual, group, or society. This assertion is borne out by the 'codes of ethics' of nursing, medicine and other health care disciplines (social work, dentistry,

psychology, etc.) not investigated here. The broader scope of the obligation poses additional problems for health care professionals that are not typically presented to legal professionals when acting in the capacity of advocates.

As the inquiry into the meaning of 'professional advocacy' develops it is noted that what remains to be exposed is both the extent of the obligation which a professional is committed to as a result of professional membership, and the function of 'professional advocacy' related to these obligations. This exploration provides the focus for Chapter Four. Further, it remains to be discovered what other obligations may be contingent upon encountering obstacles to the fulfillment of professional responsibilities. In Chapter Four, then, I propose that professional advocacy is a complex role-responsibility.

Professional advocacy is judged to be synonymous with professional role in so far as professional role involves activity that promotes the goal of the profession[5]. This raises an important distinction between the professional role of lawyers as advocates and the professional role of health care professionals. For the former it is argued the advocacy role is fairly narrow and is based on the goals of legal advocacy as discussed in Chapters Two and Three. The

---

[5]In Chapter Four I also discuss how the acquisition and development of general medical knowledge (for example research endeavors) fits into the notion of professional advocacy.

argument is made and defended that professional advocacy for health care professionals is a much broader concept because unlike in legal advocacy the goals of the profession and the goals of the professional are the same.

Thus the origin of some interdisciplinary confusions regarding the meaning of advocacy is located. It is concluded that professional advocacy for health care professionals necessarily concerns professional-patient relationships, professional-societal relationship and the intersections of these two sources of obligation for the professional. For this reason tensions may be presented to the practitioner between attending to the needs of individual patients when these conflict with the broader societal needs. These tensions require concentrated study if the goals of the profession are to be sincerely pursued.

The latter section of Chapter Four examines the Codes of Ethics for nursing and medicine and finds support for the notion that these professions assume responsibilities toward both individuals and society with regard to the furtherance of health. Finally, Chapter Five elucidates the implications for health care professionals and for society of the newly clarified concept 'Professional Advocacy'. The notion of accountability proves important if professional advocacy is to prove a potent force in furthering the goals of society with regard to health.

THE PROBLEM OF ADVOCACY

The Scope of Advocacy

It is crucial to explore what the moral foundations of different conceptions of advocacy are if the missions of the various professions are to be furthered. Since such missions are aimed at individual and societal good the various professions and society have an interest in clarifying concepts like 'advocacy' which are sometimes used to denote the behavior of professionals under certain circumstances.

Difficulties with the concept 'advocacy' are also highlighted when we note that however advocacy may be defined if it is an action or actions taken on behalf of individuals in a given system then there may be occasions when other individuals either within the system, or in the community at large may suffer resulting disadvantage. That is, any emphasis put on individual advocacy may lead to others within the system or society being disadvantaged in some way. For this reason it is crucial to explore what are the moral foundations of various conceptions of advocacy. For instance, a surgeon who advocates for payment of a heart transplant operation for her patient may inadvertently deprive others of basic health care (however that may be defined) as a result of cost-shifting.

Advocacy of the individual, in health care at least, is frequently based on Kantian type notions regarding autonomy or 'respect for persons' but this type of advocacy sometimes

seems to conflict with the social obligations of the profession based on opposing impartialist notions. Such notions may be utilitarian, or they may be social considerations which are based on principles of justice. Therefore, it proves important to consider not only the various conceptions of advocacy but also whether there are different levels - one possible level being advocacy for a given individual or group's needs - and another broader level of advocacy concerning societal arrangements.

The latter form of advocacy conceivably requires a prior critique of both societal values and any social, financial, educational or power imbalance, or environmental circumstance within the society. The existence of differing levels of advocacy poses further problems for health care providers in that the question is raised about how to rank obligations when these exist both towards the particular individual or group and towards a larger population. Additionally, the concept of a broader level of advocacy requires clarification of a given society's underlying set or sets of values; society's implicit values have to be uncovered or made explicit and examined for consistency against those values that are currently openly espoused but not practiced[6].

Reinhardt (1992) has commented upon this. He notes of

---

[6]A fuller argument for the necessity of this clarification can be found in Chapter Two.

the USA that as a society it has not yet decided whether health care is a social good or "just another private basic consumption good -- such as clothes, food and housing" (p. 2). Indeed we have not agreed as a society what our principle regarding the proper distribution of social goods should be. Many other commentators support the notion that the US does as a society think some basic level of health care is a good to be defended, however, historically actions taken to further this ideal have not been very successful. I have in mind here, among other actions, the institution of governmental schemes such as Medicare and Medicaid which have proved both unsuccessful in increasing the number of persons with health care coverage and have contributed to escalating health care costs in a variety of ways (Richmond & Fein, 1995, Salmon, White & Feinglass, 1990).

Consensus and Societal Values

Further, as has been pointed out by various commentators, such agreement regarding the status of health as a social good may not be possible. Other scholars while affirming the complexity of the issue propose that fair solutions to health care provision problems are possible. Daniels, Light, and Caplan (1996) provide an analysis of the issue of American values regarding fairness and health care delivery. By assessing the fairness of various reform proposals they aspire to ensure that "health care reform

remains a live issue in the public's mind" (p.3) thereby facilitating fair improvements in the system.

Underlying their work is the assumption that the American public does subscribe to fairness as it is characterized in constitutional notions of equality of opportunity. Confusion regarding this value occurs partly because people aren't clear that fairness is not the same as "fair deals" (Daniels, Light, & Caplan, 1996, p.3). It is confusion on the part of the majority regarding fairness, influenced by the media and the interests of big business, that has led to the idea that consensus regarding such an ideal of fairness is not possible.

Given the probability of layers in the structure of obligations attendant upon assuming the role of advocate and that such layers may provide a tension of obligations for the health care provider between the needs of the individual patient with whom they have a relationship of some sort and the needs of the broader society, it is critical to ensure this issue is clarified. Advocacy, then, is not a simple concept; it is susceptible to many different interpretations, requires different levels of enquiry and may, depending on definition, lead to divergent degrees of obligation. The remainder of this chapter is devoted to the task of uncovering the various current meanings of advocacy as proposed tacitly or explicitly by sundry groups of health care professionals and other interested parties.

Patient Advocates

Major contenders for the title of 'Patient Advocate' are physicians, nurses, and perhaps ethicists, although many other allied health groups as well as lawyers have laid claim to the role. Their assertions, assumptions and disagreements regarding advocacy are readily accessible to the reader of professional journals and participants in other current scholarly and interdisciplinary forums. Some of the issues surrounding the notion of advocacy are outlined here and in the succeeding chapters. For the sake of clarity the contentions of each group are explored separately before similarities and differences in the meaning of advocacy as espoused by each discipline is described.

The claims of each of the disciplines named above are analyzed with regard to prevalent assumptions about; a) why advocacy may be necessary, b) the definitions of advocacy for the discipline (including the discipline's understanding of the necessity for advocacy and the way this understanding affects the professional's role), c) the capability or superiority of either their members or their collective membership to advocate over the ability of other groups to do so, d) the denials of other professional groups' ability to advocate, e) the impact any perceived or actual lack of advocacy ability may have on patient welfare.

THE PROFESSIONS

Healthcare Practitioners as Professionals

Prefatory to any dialogue about 'advocacy' and the various professions it is crucial to understand the role of practitioners of various sorts as they are considered to be members of a contemporary profession. This is necessary because the general conception of a profession seems to include a reciprocal notion that obligations are incurred during the daily business of practice and that these obligations are not merely those attendant upon commercial transactions. One of most pressing contemporary questions posed by moral philosophers revolves around the issue of the survival of the helping professions in an environment where economics and not service is the primary ideal. One author, Lantos (1997) has even gone so far as to, at least partly seriously, question the need for Doctors.

In any critique of past and present health care provision conditions it becomes important to understand the role of professions within society as having a societally sanctioned purpose[7], because without such societal sanction the traditional distinction which separates artisan or tradesman from professional becomes blurred. I will argue later that the most significant difference between professional and other service groups is that the goal of

---

[7] This point about professions having a societally sanctioned purpose is somewhat controversial - a point discussed in Chapter Three.

the professional is to further a particular good for persons in the society. This is different than having as the goal of the occupation the perfection of a crafted article or the most interesting means of accomplishing a business transaction.

Additionally, the survival of the vulnerable in a given society is assumed, at least in some measure, to be threatened if professionals have as their main goal commercial success or an intent to cut costs. The reason this is so is that professionals have traditionally provided services specifically to the vulnerable. In the case of health care professionals, of course, this vulnerability would be to disease or ill-health.

The professions as they have come to be understood sociologically, are a fairly recent phenomenon. Carr-Saunders and Wilson (1933) trace the emergence of modern professions. They note that the development of associations of craftsmen began well before the industrial revolution after which time such groups underwent a more radical change in configuration.

Development of a Profession

These earlier associations or "gilds (sic)" of craftsmen began forming around the eleventh century and eventually prohibited any individuals from engaging in a craft without some sort of formal license. While, thus,

having some of the features of contemporary professions they were rather radically different in other aspects. The associations that are now considered to be professions emerged from those vocations which had a tendency to become ecclesiastically dominated; there was a flavor of mission or unselfish service about them. The service provided was to mostly to those considered vulnerable in some way.

Universities developed out of the "gilds of learning" (Carr-Saunders & Wilson, 1933, p. 289); from the gathering together of combinations of teachers and students. Originally universities did not necessarily have ties to the church but "because theology occupied so large an amount of the attention of learned men" (Carr-Saunders & Wilson, 1933, p. 291) they eventually did come under such partisan power for a while. "Surgeons, apothecaries, and notaries and ... common lawyers" (p. 291) were the first groups to become more non-ecclesiastical in nature.

Those vocations that continued longer under the influence of the church such as that of physician were among those considered fit for a gentleman. They tended to allow "a safe niche in the social hierarchy" (Carr-Saunders & Wilson, 1933, p.295) and focused on the development and refinement of a virtuous character in their members but did not guarantee substantial monetary rewards. A vestige of this history exists in that there is still somewhat of an expectation of the virtuous character of physicians although

there is public disillusionment with health care and consequently with some of its practitioners.

From Carr-Saunders & Wilson's (1933) historical account of professions an ambiguity emerges. This ambiguity involves the main purpose of professional association. On the one hand professions have ostensibly formed to serve the interests of society but professional associations also have a self-serving element[8]. In later chapters I discuss the problems that this ambiguity of intent raises for contemporary society, especially as this affects health care.

Attributes of Professionals

Carr-Saunders and Wilson (1933) noted of more contemporary professions that in general their main attribute is "the application of an intellectual technique to the ordinary business of life." This technique is acquired "as a result of prolonged and specialized training" (p. 491). It involves the notion also that the profession is conscious of itself as a specialized group. It is, then, in some way self-conscious. This self-consciousness together

---

[8] Over time, many criticisms have been raised regarding the professions. The general criticisms revolve around a view of professions as being elitist, exclusionary and self-protectionist. While I agree that these elements may well exist, my purpose is to critique the professions based on their own assertions regarding what they can provide. Such critiques facilitate 'holding' professions accountable for their assertions in the interest of individuals and society.

with the services provided allows for public recognition of its members as members of a group esteemed by society.

In 1915 during a presentation on social work as a profession Dr. Abraham Flexner described criteria which have served since as a rough set of standards against which the professional status of a group has been measured. Although there is no universally agreed upon definition of what constitutes a profession, Flexner notes that in order for a group to be recognized as such the following will be evident from their activities; a) assumption of responsibility for the usage of intellectual processes, b) ongoing engagement in scientific knowledge development[9], c) a practice orientation, d) specialized education of members, e) self-organization and self-consciousness of the group as a profession with a given purpose, f) interest in furthering the 'good' of the society.

More recently Kepler's (1981) writings lend partial support for this conceptualization of what it means to be a professional and, therefore, to have professional membership. While it is true that Kepler does not emphasize the necessity of ongoing scientific enquiry to further the profession's goal this is perhaps because the major focus of his work is on the characteristics of individual professionals. He notes that,

---

[9]Flexner does not seem to have taken into account lawyers as professionals who do not engage in scientific knowledge development as such.

> Professions are organized; the physicians have their medical organizations and the lawyers have their bar associations. A high level of education is necessary to provide knowledge not readily available or capable of being understood by all. Professions normally interact with clients for whom they provide services rather than goods. (pp. 17-18)

It is the possession of such 'not readily available knowledge' that has facilitated the societal granting of a certain level of prestige and autonomy in a professional's provision of services. But such benefits remain secure only so long as societal expectations of the profession or professional are perceived as being met. Airaksinen (1994) has written that viewed from the "sociological" perspective "professionals are benevolent experts who can justify their claims to authority and social power" because they have "personal scientific competence" and a "collective service ideal"(p.1). Both components seem necessary for validation of the group as a profession. However, Airaksinen thinks this sociological view of professionals is inadequate. It is inadequate in that it does not take into account that professions such as "medicine, education, law, and social work deal with values which come as close to being objective values as possible. Health, learning, justice and welfare are value notions in such a strong sense that the denial of their validity is incomprehensible" (p. 1).

Support for this notion that a profession espouses service ideals is provided throughout the ensuing chapters. The expressed service ideals of the professions can be discovered in their particular codes of ethics. Such written codes of ethics permit critique of the given profession. The attempt to distinguish between which occupations count as professions and which do not may seem somewhat problematic and to a certain extent it is. It is so because if we attempt to make the distinction based on service rather than commercial ideals it could be countered that many persons who engage in creative or productive activities of various sorts do take pride in their work and therefore are not motivated purely by a commercial standard. The professions under discussion here, however, profess to possess the capacity to provide a service based on a value as described by Airaksinen above. This point will prove important later for predicting the future demands of society upon health care professional-patient relationships when these relationships shift to a commercial, as they apparently are at present, rather than a predominantly service standard.

Another major characteristic of a profession, pertinent to this current endeavor, is that they are autonomous or self-regulating. Indeed, it has been noted by various commentators (Carr-Saunders & Wilson, 1933; Newton, 1988; Parker, 1994 etc.) that the degree of autonomy is related to both the power the profession holds and the esteem in which

it is held. As Parker (1994) asserts, "the extent of professionalism can be equated with the extent of the social mandate achieved by the profession for defining the terms of its own operation." Parker also proposes, questionably at least with regard to this being historically a defining characteristic, that the professions are "relatively well-paid for exercising the professional skills and judgement for which autonomy is required" (Parker, 1994, p.32). Finally the profession has its own view of itself and is persuasive in getting non-members to acquiesce in this conception.

Others such as Kultgen (1988) see professionalism more as some sort of moral and/or cognitive way-of-being with regard to, or a diligent manner of approaching, any sort of work upon which the person has embarked. This wholeheartedness reflects a character that has engaged in the project of self-fostering of virtues. On this view the distinction between what counts as a profession and what does not must be somewhat arbitrary. However, there are expectations that members of professions will exhibit certain characteristics, therefore the notion of professional virtues is considered as an integral part of the analysis.

The purpose of this current project, however, is **not** to make fine distinctions regarding what it is to be a professional. It is, rather, to discover the meaning and

obligations of advocacy as viewed from the vantage point of the profession's own tenets. The debate about what professionalism is, therefore, will be examined only in light of the professions discussed below.

PHYSICIANS AND ADVOCACY: EVOLUTION OF THE PHYSICIAN PATIENT RELATIONSHIP

Fiduciary Relationships

For the medical profession as well as for other professions (at least for those that have been universally recognized as mature professions such as medicine, law, clergy, teaching) the relationship of its practitioners to the population of its concern is usually characterized as fiduciary. Zaner (1991) notes that the fiduciary relationship has been "typically understood as a form of paternalism for which beneficence is the governing principle" (p. 45). Such relationships have been described by various authors as being based on trust. Zaner finds this view of the concept of trust with regard to physician patient relationships problematic because it leaves out the patient's perspective.

There are, thus, at least two ways in which trust may be characterized as this relates to the professions. On one perspective there is the notion that I can, in general, "trust" a professional to provide the service needed because of the specialized knowledge and skills he or she is supposed to possess. This form of trust seems to connote

reliance; one relies on the professional based on the profession's certification[10] of its membership. However, from a patient's perspective there may be no other basis for trusting the physician than the societal sanction of her professional attributes and public acknowledgment by the profession of its obligations towards the population of its concern.

A more complex subjective account of trust seems to involve prior experience of the trustworthiness of the other as a result of an ongoing relationship of some sort which may or may not exist in a given physician-patient relationship. Trust of the first kind as Pellegrino and Thomasma (1993) point out "is the most problematic when we are in states of special dependence ... (T)his is the situation in our relationships with the professions that circumstances force us to trust. We are forced to trust professionals if we wish access to their knowledge and skill" (p.65). By this they seem to mean that in order to surmount problems that require the aid of professionals we either have to entrust ourselves to their care or succumb to the crisis. In entrusting ourselves we are relying on the professional to keep our best interests at the forefront of their treatment decisions. This point is explored more extensively in Chapter Three.

---

[10]This is not necessarily a formal certification via examination, although it often is.

The physician, then, as a professional is a holder of the trust placed in him or herself by societal members as a result of the acquisition of esoteric knowledge, training and a profession of service intent. Viewed from the perspective of the western medical model of health care provision, the physician has tended to be seen as primary patient advocate[11].

This is so, in part, because the physician-patient relationship is viewed as the dominant form of health care professional-patient relationship; it is the most powerful of such relationships. I mean powerful in the following sense: medical practitioners have managed, at least until recently, to control the terms of their practice arrangements. Additionally, they have also managed to convince society of their importance in addressing health problems (Starr, 1982). Their constituents are individuals who have been perceived as having the freedom[12] to choose the best physician to help them with their medical needs. The importance of this aspect is that in some sense the physician-patient relationship has remained, until recently,

---

[11] Although the truth of this statement regarding the primacy of physician advocacy has been vigorously debated. This partly because in institutional settings it is other professionals such as nurses who may actually have a more sustained relationship with a patient and are thus privy to the patients multiple needs. Such disagreements regarding who is the advocate, as I shall show, are misconceived.

[12]Although 'freedom' may be to strong a term to use under conditions of vulnerability.

relatively free of the influence of outside interests. By 'outside' I mean such interests as have the power to direct the physician to act alternatively to what she, ideally in concert with her patient, has taken as being in the patients best interests[13].

Trust, then, as it relates to the physician-patient relationship, is necessitated in the sense that the seeker of the physician's services is lacking in the knowledge and/or ability to provide for herself what is needed to regain or maintain health. The individual may also be unable to assess the quality of service or even her own need for the service. That is, the patient in seeking the services of the physician expects the contracted physician to act in her best interests with regard to health or illness matters. In short, it is an expectation of the physician-patient relationship that it ensures attendance to the best interests of the patient.

It may be objected that there are occasions when the patient's best interest is not the main purpose of a physician visit. For example, physicians who screen potential employees of a company for their physical ability to do the work are not in the same sense participants in a physician-patient relationship. The professional moral obligation in such circumstances would be to ensure the

---

[13]There have, of course, always been exceptions to the physician's relative freedom of practice. However, the predominant model has traditionally been the one described.

potential employee understands what is the primary goal of the physical examination. However, on discovering a problem the company physician does, as I shall argue later, have an obligation to ensure the patient is aware of the nature of the incapacity and is referred appropriately.

Since the potential beneficiary of services is lacking the means to achieve or maintain health and in addition does not always, or in most cases, possess the ability to assess either how well that need is being met, or whether the need could in some manner be better met with alternate therapeutic interventions, she is vulnerable to the provider. As vulnerable, that individual is forced either to trust that the professional will actually act with the beneficiary's best interest in mind, or to reject medical care and continue with the unmet need.

Best Interests

Of course, inherent in the notion of any such relationship is the fact there is also some benefit accruing to the physician in providing the service. That is, physicians should at minimum be able to provide food and shelter for themselves and their dependents. Also there has traditionally been thought to exist an element of altruism in the motivation to provide service; but even in those instances where the major portion of the motivating force seems altruistic it is usually maintained that there is some

psychological benefit to the altruist. The relationship must meet what might loosely be termed a need in the physician. Nevertheless, the general expectation of such a relationship has been that the patient's best interests do take precedence over provider interests when there is a conflict of interests. For example, in those cases where the financial gain for the physician may be greater if a poorer quality care is given the physician is expected to forego the greater gain.

Conflicts of interest in the context of physician-patient relationship have always existed to some degree[14] but have become ubiquitous in the current United States (US) health care delivery system, a fact that will be discussed in greater detail later. The scope of these actual and potential conflicts of interests are widening exponentially with recent developments.

Changes in the Nature of Medical Fiduciary Relationships

Tracing the evolution of the fiduciary or the "dyadic" physician - patient relationship is helpful both to our understanding of the perceived obligations of the role from the practitioner's point of view and our understanding of the impact of prevailing societal values with regard to health. Since it has been noted that professions are

---

[14]Fee-for-service health care had its own set of problems in this regard.

accountable to society it is important to discover the development of medicine's accountability to the population of its concern.

Siegler (1985) sketches the history of the physician - patient relationship up to its contemporary standing. At each stage of development conditions which could plausibly be interpreted as those of 'patient advocacy' have been highlighted to show what the ostensible need for advocacy was. "The age of paternalism" has lasted thousands of years and is based on "patient dependence and physician control" (p. 714). During this time the physician-patient relationship was avowedly unequal with the ignorant and unwell patient reliant upon the physician to provide "symptomatic care". The care was symptomatic because of the limitations of medical knowledge during this time period. On this perspective, advocacy would have to be seen as helping the patient to resist or bear the illness or illness-inducing elements which presumably he or she would be able to do less well on his or her own. Interventions might include the palliative treatment of such things as pain or fever but most likely would not involve cure. In the best case scenario, the physician had knowledge of the patient's disease. Provision of this knowledge would allow a certain degree of intercession on behalf of the patient against the elements thus it was to varying degrees psychologically supportive and provided certain environmental information

which satisfied "many basic human needs" (Seigler, 1985, p. 714).

Following this non-technological period was what Siegler terms the "Age of Autonomy". Roughly this era extends from the advent of antibiotic development in the 1940's to perhaps the late 1980's. Major advances both in understanding pathophysiologic processes and in the development of complex chemical, mechanical and surgical technologies enabled treatment of disease and restoration of health in persons suffering from what would previously have been disabling if not fatal diseases.

During this time there were various important factors which impacted on and therefore started to re-formulate the physician-patient relationship especially in the United States. There was an increasing post-war interest in individual rights which included the notion of the importance of informed consent in medical decision-making.

This led to a subtle shift in malpractice law from favoring the physician to favoring the patient. As Chapman (1984) points out, malpractice law was inherited from the English via Thomas Percival who is notable, among other things, for his writings on medical ethics and about the proper conduct of men of medicine. Malpractice law had hitherto tended to protect the physician for several reasons but probably most importantly in that, a) it held physicians accountable for injury by "specific intent" but not for

"damages if the injury to the patient resulted from ignorance or neglect (p.89)", and b) because of the 'Locality Rule' which essentially said a physician's performance should correspond with that of others practicing in the same capacity in the same community. Often physicians practicing in more primitive or isolated areas were less well-trained; therefore, in those areas the community standard would not be set very high. With increased interest in an individual's right to informed consent the tendency to favor the defendant was reversed to a tendency to favor the plaintiff.

Fiduciary Relationships: Patient Autonomy

These changes, then, contributed to a potentially more equal physician-patient relationship, and perhaps even gave the patient the upper hand in such interactions by implying that there could be self-determination of care. Physician advocacy viewed from the perspective of the 'age of autonomy', then, would seem merely to mandate the provision of adequate information for the patient to make treatment decisions followed by provision of the treatment or to provide assistance in gaining referral to an appropriate provider. There would be an underlying charge for the physician to have an adequate grasp on the case based on appropriate history taking and physical findings and to have access to the appropriate medical information in order to

communicate the options effectively to the patient.

But would these really be the only obligations? One question about this type of relationship is that it is difficult to say what constitutes 'sufficient' information for the patient's decision-making. Another problem involves what to do if a patient's wishes in a given situation seem counter to her best interests. It is also unclear what the physician's role might be in those cases when a beneficial treatment option is not readily available to the particular client; that is, it is not clear on this model to what extent the physician has societal obligations.

Healthcare Provision: Changes

As set out by Siegler, it appears to be assumed that there was or is in fact equal access to the necessary tests and to physician treatment for all or that advocacy on behalf of those without adequate resources is not a problem that falls within the physician's domain of concern. Indeed, wider societal issues of access to care for all does not seem to present itself as an issue to be addressed. It is an interesting fact that the American Medical Association's current and past code of ethics maintains the physician's freedom to choose whom to serve except in emergency circumstances. Other professional codes such as that of the American Nurses Association do not include such a choice for individual practitioners. This anomaly is investigated

later.

But perhaps to draw attention to this deficit in Siegler's analysis is unfair. Siegler's article is after all about 'dyadic' physician-patient relationships and does not profess to be addressing anything more. The question, however, that is still being posed contemporarily seeks to determine what are the physician's broader social obligations under this model. This is an important question currently in light of accusations that physicians have played a major part in bringing about the current health care crisis. Stronger accusations center around physician greed but there are also charges of physician indifference, coupled with tunnel vision regarding their part in the evolving problems. The contemporary era, or the "age of bureaucracy" (Siegler, 1985, p.714), finds the physician-patient relationship in dire straits. Here Siegler writes, of the evolving health care climate,

> The physician will be accountable to multiple interests including employers (health maintenance organizations [HMOs], hospital corporations), hospitals, insurance companies, and government. The physician in the Age of Bureaucracy will have divided allegiances. (p.714)

The 'dyadic' relationship will in most cases cease to exist, succumbing as it must to more pressing interests. A common accusation in the ethics, social policy and healthcare reform literature has been that the medical community has in

fact been instrumental in bringing about the current health care crisis. Siegler, however, now urges that physicians and patients forget their differences and unite to fight this economic encroachment upon the previous symbiosis of the physician-patient relationship. This seems a somewhat naive view of the nature and power of economic concerns prevalent in both yesterday's and today's health care scenario. It implies that economic interests will shrink in the face of a physician and patient group lobby. Further, it fails to recognize that physicians might be in better position than patients to advocate for change. Siegler is acknowledging the current danger that whatever individual patient advocacy (however that may be defined) did exist will cease to be. Moreover, advocacy on a broader level does not appear a concern for physicians on any interpretation of advocacy examined so far by Siegler.

Physician Obligations

A look at the evolution of the code of ethics of the American Medical Association (AMA) proves enlightening with regard to what the perceived obligations of the profession are. The first code was written in 1847 and adopted, as mandated by the AMA, by all state and local medical societies in 1855 (Reiser, 1995). Much of the content was drawn from the British physician Thomas Percival's Medical Ethics which had an emphasis on "moral obligations

(arising) out of a tacit compact between the profession and society" (Baker, 1995, p. 5). The AMA version was modified to fit the American culture. It had three main sections: "The obligations of doctor and patient toward each other, the relationship among physicians themselves, and the interaction of the public and the profession" (p. 80). The code as Reiser explains it is remarkable for the fact that there is not only a strong emphasis upon the physician's responsibility towards those in need but also a strong emphasis on the responsibilities owed to the physician by the patient. Apparently for example, patients should recognize the industry of physicians as it is employed on the patient's behalf.

The 1847 code lays out physicians' responsibilities to society which seem mainly to concern physician advice regarding "quarantine, public hygiene, medico-legal issues, the location and content of hospitals... preventing the patient from taking quack medicines" (Reiser, 1995, p. 99) and the duty to take personal risks in care-giving during periods of epidemic. There is also an exhortation to do *pro bono* work for those in need but there were limits placed on this. However, there is less emphasis in this code than in later codes on the physician's duties to attend to the broader societal issues regarding, for example, what constitutes fair provision of health care.

The latest two revisions of the code in 1957 and 1980

have shown significant differences from earlier codes. The 1980 revision includes in Principle III an exhortation to seek changes in laws which might be "contrary to the best interests of patients"; and the last Principle (VII) specifies that "A physician shall recognize a responsibility to participate in activities contributing to an improved community" (Kepler, 1981). Earlier versions of the code were significantly less focused on the social responsibilities of professionals. Thus it seems at least plausible to suppose that contemporary physicians do have a responsibility to take into account societal needs in addition to individual advocacy ones. That is, they may -- as it was pointed out earlier -- be required to advocate both on an individual level and on a societal level. It will be demonstrated later that this scope of focus, together with personal fiscal concerns, may present the physician with a tangle of obligations, and strain the traditional fiduciary relationship. The key point to note at present, however, is that the contemporary AMA code of ethics does evince that obligations exist for the physician on both the individual and societal level.

Types of Medical Advocacy

Jecker (1990) has also noted the paradoxical nature of physician obligation problems. She observes that such questions regarding "how best to balance patient advocacy

responsibilities with broader social responsibilities" (pp. 125-126), have been typically viewed in three ways. She examines these views which she has distilled from the current literature as being the most extant and distinct. The first or "Unrestricted Advocacy" essentially affirms that the physician's obligation is directly to the individual patient's welfare over all other considerations.

"Minimally restricted advocacy" however, is slightly less directly dependent on individual patient welfare although it is aimed at facilitating the welfare of such individuals. On this conception acting in a patient's best interests remains important and a physician's 'authority to so act is maintained but there are constraints which are facets of this "ethic of agency" (Daniels, 1987, p. 71). These constraints upon the physician clinical decision-making are that such decisions must be:

> (A) competent: up to professional standards of care; (B) respectful of patient autonomy; (C) respectful of other patient rights, e.g. confidentiality; (D) free from considerations of the physician's interests; (E) uninfluenced by judgements about the patient's worth. (Daniels, 1987, p. 71)

Daniels 'ethic of agency' allows for fairness in health care allocation in times of constricted resources. It does so because, ideally, "the physician's primary responsibility" is set out by the "principles of professional ethics" which

"derive from the roles specified by just institutions" (Jecker, 1990, p. 126). This perspective, which Jecker acknowledges as that of Daniels' (1987), places justice issues as the primary consideration. Upholding just conditions best serves any given individual's interests in general and over time, even though as a consequence of justice considerations there may be occasions when a given individual's interests may not be fully promoted by the physician. The reason that in certain instances a given patient's interests may not be promoted is that it is in that person's interests in general (as well as in other individual's interests) that this individual's interests are not promoted presently. Daniels' view is reliant upon the idea that if institutions are just, then, professional decisions which correspond to the requirements of these institutions would be just. However, Daniels acknowledges that just health care institutions are not even close to being a reality in the US (1987, pp. 74-75). More recently he has proposed ways of assessing the fairness of health care reforms (Daniels, Light, & Caplan, 1996).

On the third paradigm "maximally restricted advocacy" the physician is committed to ensuring that the interests of the society at large are favored whenever there is a conflict between the interests of the patient and that of the broader society. This third position, the one Jecker favors, focuses on advocacy which is inclined more towards

the welfare of the larger society and allows this duty to take precedence over the interests of an individual. The two reasons given for Jecker's preference are societally based. Firstly, "a commitment to serve the public interest has historically gone hand in hand with physicians' commitment to promote patient welfare" (Jecker, 1990, p.127). This is a publicly endorsed expectation of the physician; but also much public funding and support goes into the training of physicians. Moreover Jecker affirms, this view of "maximally restricted advocacy" has prescriptive force since it is a societal demand of the professional.

The paradoxical nature of this type of advocacy requirement for physicians, which seems to neglect the fact that attention to society's needs proves important for the reason that society consists in social individuals, renders it suspect. It is also rendered suspect on a second and related count; that is, that our current societal attitudes seem to be requiring of physicians both attention to the public good and attention to the individual patient[15].

The problem hinges, in part, on the fact that giving priority to an individual's needs over societal considerations can be problematic to the society but giving priority to societal considerations may fail to respect the

---

[15]Thus, it does not provide for the physician an adequate rationale for the proper direction of her decision-making in situations of conflict, nor is it able to satisfactorily address public demands.

notion that individuals are unique beings. They are beings who, absent problems that deprive them of this, are self-conscious entities possessing aims and goals and engaging in meaningful relationships with other such unique individuals. Therefore, attention to societal needs and attention to individual needs are important.

During the course of this endeavor it will be argued that Daniels' view of the advocacy problem perhaps comes closest to explaining the advocacy role of health care professionals. Further, health care professionals may as a result of their advocacy obligations also be obliged to criticize unjust institutions.

Physician-Patient Relationships: Fleeting Contact

A further question which surfaces during any discussion surrounding physician-patient relationships is that such relationships imply that the physician does, in fact, have some sort of interaction with the patient that is more than transitory; otherwise it cannot validly be termed a 'relationship'. Wolf (1994) asserts that "in many settings the physician is probably the one best situated to advocate for the patient" because she is "knowledgeable about the medical circumstances and versed in the patient's preferences" (p. 36). But in an era of specialization in medicine many of the contacts persons have with physicians are a) fleeting, and b) about a particular facet of that

individual's body. Therefore the 'nature' of the person might be not be known to any significant degree. This problem is especially acute in today's 'Managed Care' environment. For in such a setting, the best financial interests of a given employer may mandate switching care provider groups or companies sporadically thus destroying the employee's ability to have an ongoing relationship with a provider of their choosing. Physician-patient relationships of any sort may prove a receding specter of what some will regard as a comparatively utopian health care delivery system.

Family practice, psychiatry and oncology are among the areas of medicine which have more typically fitted the ideal of a physician-patient relationship. Christie and Hoffmaster (1986) highlight the physician-patient relationship as "the core" (p. 17) of family medicine. The clue to successful care of a patient stems from the familiarity of a "close friendly relationship between physician and patient". Such relationships are holistic. Many, including Peabody as long ago as 1927, have noted that this has not tended to be true of hospital care which is, in general, impersonal. It seems that it will become less and less true also of primary care. Primary care especially in rural or inner city areas is becoming more and more the domain of advanced practice nurses (APN's) and physician assistants (PA's). The import of this is that while some provider-patient relationships

may be preserved, the physician-patient relationship may be at risk.

Holistic Relationships

The extensive professional experience of this author is that physician specialists do not tend to have easy access to, nor typically wish to have, a holistic view of the hospitalized patient. In the recent past, it was a fortunate patient who had a primary physician to actively co-ordinate care among various specialists and allied providers. Even more favored was the patient who had the luxury of being attended to by his or her own family care physician. That is, the coordination of care by someone who knew more of the patient than mere physical characteristics and the shortcomings thereof, became rarer. Therefore the sort of 'ideal' care which includes taking into account the patient's life-preferences and values is not readily provided by specialists .

In summary then, 'advocacy' for physicians involves the notion that a need for health care exists. This need cannot be met by individuals acting on their own behalves due to a deficit of knowledge, resources or ability. This deficit is such that physicians with their professional expertise are both in a position to at least partially redress it and are expected by society to so do. There continues, however, some disagreement among these professionals about whether the

needs of society or the needs of individuals take precedence when perceived obligations towards both parties conflict. Some of the disagreement arises from the nature of the individual as a constituent of both parties. That is, the individual is both an individual with needs and a member of the society with whose collective needs hers may clash. Physicians see the promotion of patients' best interests (however this is viewed) as stemming from the fiduciary nature of the physician-patient relationship, the characteristics of which are represented in the AMA code of ethics. What is not terribly clear in the literature is what "best interests" means (as these have been defined in a variety of ways) nor to what extent a physician is obliged to promote them both on an individual level and perhaps by political action.

Although not much has been written regarding the profession's view of the superior/inferior ability of other professions to advocate for patients, it is reasonable to assume physicians regard themselves to be best positioned for this activity based on their conceptions of advocacy described previously in this document. Interestingly, compared to the literature written by allied professionals on advocacy, physician-authored articles on the subject are relatively rare, necessitating a certain amount of extrapolation from the writings of others about medicine's purposes in this regard.

NURSES AND ADVOCACY: EVOLUTION OF THE NURSE-PATIENT RELATIONSHIP

Nursing as Distinct from Medicine

The following exploration of the development of nursing as a profession exposes some, perhaps, not commonly understood differences between nursing and medicine. This comparison is important if meaningful communication between the disciplines on the question of advocacy is to be achieved. Twomey (1989) has highlighted some such differences, asserting that there are things nursing does that the philosophy of medicine doesn't account for. Nursing more than medicine is geared towards health promotion, preventive strategies and a viewing of the patient as an individual who is inextricably bound up in her environment. In the case of hospice care, Twomey (1989) notes "the medical model no longer holds any relevancy for the meaningfulness of the patient's life" (p. 29). He proposes that the differences are crucial to any debate about the purposes of intersecting disciplines since they may give rise to different moral issues. This point will be explored further. While such alternate perspectives may give rise to different moral issues, these are also both disciplines geared towards serving the vulnerable. Therefore it is expected that many moral issues will be of mutual concern. In such instances, then, intelligible discourse between the two groups will be crucial to the furthering of the welfare of society.

Nursing as a Profession: Problems

The development of nursing as a profession has had a more troublesome course than that of medicine. There are several well-documented reasons for this. Nursing is a predominantly female discipline; as such its progress has echoed that of the status of women in society. Additionally, there are different levels of educational preparation for nurses. This disparity has led to one of the most vital problems for nursing leaders, that is, how to unify the profession. Unity is seen as crucial for the main reason that without unity[16] there is little power to effect change or gain autonomy. Power (and perhaps autonomy) is necessary if nursing is to effect change that will benefit the population of its concern. That is, change is required in order for nursing to further its goals with regard to the health of individuals and groups within the society.

Chamblis (1996), a sociologist who studied nurses working in institutional settings over a period of years observed, "For nurses to do good they must have the *power* to do good" (p. 184). He was responding, in part, to his discovery that most of the ethical problems nurses and others encounter in institutional settings aren't so much dilemmas or decisional problems but rather the result of institutional blocks to what was recognized by the nurses as

---

[16] It is recognized that unification of the profession is only the first step to engendering change.

necessary action for good care. However, it is not only within institutions that barriers to health arise.

Nurses comprise the major work force of the health care industry (Nursing Management, 1995). Concerted efforts on the part of the nursing profession should theoretically be able to bring about some reforms of the system (whether this is institutional or constitutional change). Such systemic reforms have been seen as necessary by nursing leaders if care is to be provided for all those whose well-being depends on it and to the extent their well-being depends on it.

However, this disunity within the profession has contributed to the lack of power of the profession to impact the health care delivery system in various ways. One effect of the lack of cohesiveness is to weaken a potentially politically powerful force. Although numerically nurses, as has been stated, constitute the largest body of health care workers, the proportion of nurses who belong to the professional organization is small and consists predominantly of those having educational preparation at the baccalaureate degree level or higher. The ANA is the primary professional organization for US nurses. It has had some success in promoting policy changes which impact on the health of the society[17].

---

[17]See ANA's multiple publications. The most recent effort is the ANA drafted 'Patient Safety Act' introduced into the senate on May 8th, 1998 by Senator H. Reid.

It is thought by some[18] that the principal manner in which this source of friction among professional nurses may eventually be remedied is to institute a policy which would mandate baccalaureate education as the minimal preparation for the professional nurse. A baccalaureate education is deemed superior for the profession's purposes because it widens the scope of patient care from a task-oriented perspective to accountability for the planning and implementation of holistic care for "focal clients who are identified as individuals, families, aggregates, and community groups" (Primm, 1986, p.2). Also it is expected that among nurses of similar educational background there will be more solidarity of purpose and that this will in the end best further nursing's objectives. Others, while agreeing that this is a necessary condition of professional unity, do not think it a sufficient condition. I shall argue later that an additional requirement is attention to the moral foundations of professional affiliation. Nurses holding a baccalaureate or higher degree as of 1992 constitute 22% of the 2.4 million registered nurses (Fagin & Lynaugh, 1992).

The Report of the Ad Hoc Committee on Titling and Entry into Nursing practice (1986) traces the progress of

---

[18]This is an ongoing debate involving innumerable nurse scholars, leaders and practicing nurses.

nursing's quest to make a baccalaureate degree the minimum educational preparation for professional nurses. It states that the issue was considered for the first time in 1967. Since that time the debate has been ongoing. Resistance has come, not surprisingly, from faculty and graduates of both associate degree schools and diploma schools (although diploma schools are now almost extinct). Resistance has also come from other areas for several reasons. Baccalaureate education is more costly in terms of both money and time. Periodically the US has experienced a shortage of nurses which contributes to the resistance as demand goes up in times of shortage. "In 1984, the ANA House of Delegates established the goal that by 1986, 5% of the states would implement the baccalaureate in nursing (as entry level education) for professional nursing practice."

Another factor which it is thought will augment the power to effect change includes the notion of autonomous practice. This is becoming a realizable goal for some nurses who pursue advanced degrees and consequent to this, certification as advanced practice nurses. Additionally, and as increasing numbers of nurse scholars turn their attention to the analysis of nursing's relative impotence in health policy matters, it is hoped to discover ways to promote the goals of the profession. One of these ways, I shall argue, involves the idea that the interests of society may be furthered by collaboration with other health care

professions. Each group adds a unique focus which should assist both with comprehensiveness of vision and power to address the needs of individuals in society.

Nursing: Historical Evolution

Whilst almost always having some positive status historically, nursing has gone through its less reputable eras. Flaherty (1982) describes the historical view of nursing as arising first from images of nurse as mother taking care of infants, later expanded to caretaking of others in the family or society. Knowledge of such caretaking activities was of an experiential rather than scientific nature. There was also in the middle ages a religious influence which gave nursing an even more self-sacrificing or altruistic image. Indeed as described by sociologist Una Maclean (1974), "It was Christianity which specifically enjoined the care of the sick and suffering as a duty upon the faithful..." (p. 49).

A third image of nursing which was not as positive involved the nurse as "servant" (Flaherty, 1982, p. 68). This ignominious period in nursing's history according to Flaherty ran from the "sixteenth to the nineteenth" century. Such women were personified in fiction by Charles Dickens' slovenly, alcoholic Sarah Gamp who nursed as a last resort to earn money but had no pretensions to any expertise. Because of its reputation as the occupation of 'low' women,

nursing was not considered a fit employment for any but these.

It was during the Victorian era, an era of great scientific progress, that nursing under the influence of Florence Nightingale began its reformation. It developed into an occupation suitable for gentlewomen. In 1836 the first modern hospital was instituted in Kaiserwerth, Germany by Mr. and Mrs. Fliedner. It provided a three-year training for women of good 'moral standing' in principles of hygiene, current scientific knowledge, pharmacology and religion (Deloughery, 1977). This institution had a powerful influence on Florence Nightingale who was a frequent visitor.

Nursing did however continue to differ from medicine in its intentions and purpose. In a frequently quoted passage from Notes on Nursing (1859) Nightingale herself notes,

> It is often thought that medicine is the curative process. It is no such thing; medicine is the surgery of the functions, as surgery proper is that of limbs and organs. Neither can do anything but remove obstructions; neither can cure; nature alone cures. Surgery removes the bullet out of the limb, which is an obstruction to cure but nature heals the wound. So it is with medicine; the function of an organ becomes obstructed; medicine, so far as we know, assists nature to remove the obstruction, but does nothing more. And

> what nursing has to do in either case, is to put the patient in the best condition for nature to act upon him. (pp. 74-74)

Deloughery (1977) verifies the fact that "medicine and nursing had independent origins and existed for many centuries without much contact" (p.4). The differences between the two groups, Medicine and Nursing, may be seen as that of focus. Medicine and Surgery were focused on symptomatic control of disease and, where this was available, cure, whereas Nursing was focused on comfort care of the individual. During the pre-Victorian era medicine and nursing were both relatively undeveloped. It was a succession of social developments that facilitated the growth of these disciplines. The social developments included such things as "the Crusades, the Renaissance, the Reformation (and) the Industrial Revolution" (Deloughery, 1977, p. 4) which culminated in technological and scientific advances and had practice implications.

Definitions of Nursing

The public image of the profession of nursing as portrayed by various media both in the past and currently is an inaccurate, if not outright deceptive picture of nursing's purposes and of the nature of the practice of nursing. Nurses have typically been viewed as either some sort of inferior physician, that is, not as members of a

distinct profession which possesses its own body of knowledge, or as a handmaiden or servant of the physician carrying out tasks that are solely dependent on "doctor's orders". Other images of nurses have been even less flattering. For example, some television shows, like the one entitled "Angels" which aired in the early 1990's, showed nurses as sex objects. Strong negative responses on the part of the American Nurses Association (ANA) plus expressed outrage from the nursing community in general did eventually manage to terminate "Angels" run.

Nursing as a profession is continuing to struggle to change such misconceptions. A misunderstanding on the part of society of the complexity of skills and knowledge required to practice nursing has contributed to the ease with which economy-driven managed-care organizations (MCO's) have been able to substitute unskilled 'unlicensed assistive personnel' (UAP) for registered nurses leaving a handful of RN's to supervise such personnel while still being held accountable for the patient care delivered. This, of course, is only one of the ethical problems posed by the new health care environment. My point here is not to draw out the fact of the new environment as being especially problematic, (previous US health care arrangements had their own sets of problems) but rather to note that nursing must maintain vigilance in monitoring health care delivery conditions which are likely to adversely affect the population of their

concern.

At the same time the profession proceeds via the work of its theorists and scholars to, in Twomey's (1989) words, define "the process of maintaining health as the core of (nursing's) distinctiveness" (p. 28). Contemporary and historic nursing leaders and theorists have offered definitions of nursing's purpose that somewhat support Twomey's assertion. They have provided a variety of theories and conceptual models to act as frameworks to guide nursing activities in relation to its population of concern and to fulfill in action its philosophy.

Nightingale's definition of nursing can be seen in the last line of the previously quoted passage from Notes on Nursing. Gaylord and Grace (1995) have construed this "putting the patient in the best condition" for nature to do its work, as advocacy[19]. They note that to do this one must first have an "understanding (of) what the best condition is for that individual" (p. 14). Nightingale saw that it was important to understand what nursing was but did not think the elements of it had yet been adequately defined. She did however assert that "the laws of health or of nursing" are "in reality the same" (p. 6).

Virginia Henderson (1991), a nursing leader whose work

---

[19]While this may initially seem a strange conceptualization of advocacy, I shall argue later that professional advocacy consists in actions taken to further the goals of the profession.

is highly respected within the profession, crafted a definition of nursing which was first published by the International Council of Nurses (ICN) in 1961. She notes that the definition represents the crystallization of her ideas about nursing over a period of time.

> The unique function of the nurse is to assist the individual sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as quickly as possible. (p. 21)

Definitions of nursing proposed by other nurse scholars are fairly consistent with Henderson's. It is out of such philosophies of nursing as these that nurse theorists construct their theories and conceptual models. These frameworks which describe nursing's special purposes tend to view persons holistically. They address such needs as restoration of health, health promotion, adaptation to chronic disease, comfort in terminal illness, and environmental impacts. They prove useful when attempting to understand the nature and responsibilities of the nurse-patient relationship out of which advocacy needs become evident (regardless of how advocacy is defined).

Some have suggested that the 'Ideals' of nursing as set out by various nursing theorists are incongruent with the

public's conception of nursing. These public conceptions, though, do not currently and probably never have accurately echoed the truth about the nature of Nursing. Nursing does have a purpose that intersects with the goals of medicine but that purpose is not necessarily always synonymous with medicine's purpose. However, an examination of society's expectation of nursing with regard to advocacy is worthy of investigation.

The Nurse-Patient Relationship

In the past couple of decades much has been written in the nursing and ethics literature about what advocacy means for nurses. There is great diversity in the propositions concerning the meaning of nursing advocacy. These propositions are sometimes descriptive and sometimes normative. They arise from interpretations of what is demanded by the nurse-patient relationship. In general nurse-patient relationships in institutional settings are also somewhat under the influence of physician-patient relationships. Exceptions to this are APN's who may have total accountability for their patients including responsibility for obtaining referrals and consultations when these are assessed to be required by a given patient's condition. The majority of APN's do not work in institutional settings, although the number who do is growing.

The nurse-patient relationship has also been described as fiduciary, that is, as previously discussed, based on trust. However, what is essential to the nurse-patient relationship is that it is 'ideally' guided by a philosophy of nursing that focuses on the health or well-being of the individual and that the individual as far as he or she is able is integral to the determination of what constitutes well-being. The individual patient's own view of the situation is crucial to the care-planning process. Such philosophies operationalized via nursing theories and conceptual models guide both descriptions of the nurse's role in the daily caring for patients, and prescriptions regarding what the nurse ought to consider as duties. There has been a fair amount of discussion in the nursing, medical and ethics literature decrying nurses' ability to advocate for patients in an environment which places constraints on nurses' freedom to so do. Since other providers are increasingly subjected to external constraints to practice, the arguments surrounding nursing advocacy cannot fail to be instructive in these areas also. Advocacy roles for nurses have been variously described both by nursing insiders and by interested others. For the sake of brevity and clarity these arguments will be grouped under models.

Nursing Models of Advocacy

'Patient rights advocacy' is a model that has been

proposed as a suitable one for nurses. On such a model according to Annas (1974/1990) the nurse with extra training in law and the "art of advocacy" (p. 86) would be suited to defend and protect the patient's rights in institutional settings. This would not, apparently, be part of her nursing role, though; it would be more like a new 'profession'. Defending patients' rights as part of the nurse-patient relationship has also been accepted by many nurses as an obligation of the role. However, not all nurses posses those characteristics necessary for the defense of patient's rights (Gaylord & Grace, 1995). Defense of patients' rights requires: a) an understanding of what those rights are, b) the freedom to tackle the forces infringing the rights, and c) the capacity to address such infringements. Needless to say, many have not seen the bedside nurse as having the time, education or resources to champion the patient's cause to the extent required on this model even if it were generally agreed upon to what rights patients may lay claim. Patient rights' advocacy would, it seems, be guided solely by the principle of autonomy.

Gadow (1980/1990) has proposed 'existential advocacy' as the type of advocacy befitting "a philosophy of nursing which unifies and enhances the experience of the individuals involved" (p. 41). This advocacy stems from the unique and more than fleeting relationship of nurse and patient. In such relationships as described by Gadow there is a two-way

flow in the course of the interaction. It facilitates the person's understanding of the "unique meaning which the experience of health, illness, suffering, or dying is to have for that individual" (p.42). Such an intimacy does not preclude patient rights advocacy, of course, but would make it only one possible facet of the connection. Several questions are raised both by Gadow's model and by patients' rights models. Two such problems are: a) it is not clear what the nurse's obligations are when such advocacy is made impossible by environmental hindrances,and b) it is not circumscribed to what extent supererogatory actions may be expected of, or undertaken by the nurse as a result of assuming advocacy responsibilities.

Bernal (1992) seems to be ascribing to the nursing profession the view that its practitioners are the most suitable defenders of patient rights. Gaylord and Grace (1995) counter that, such responsibilities may accrue to a variety of persons within institutions as a result of confrontation with rights violations. It just so happens that because the nature of nursing results in the nurse, as a rule, spending the most extensive time with the patient, she will be the one who is most frequently confronted with moral violations. Also contrary to Bernal's assertions, the writings of nursing leaders such as Nightingale and Dock, when interpreted contextually can be understood as mandating the supererogatory behavior of nurses on the behalf of both

individual patients and groups of medically disadvantaged persons, rather than blind obedience to more powerful aggregates.

Such accusations, then, on the part of nursing's critics seem somewhat unfair and represent a superficial understanding about the history and ideals of this profession. Nevertheless, they have provided opportunity for a more public clarification of the foundational assumptions which ground nursing theory and practice.

More recently, the confusion regarding nursing advocacy has been taken up and explored by European nurses in the form of scholarly articles and empirical research. Snowball (1996), designed a small qualitative study to uncover ward nurses' understanding of advocacy and its obligations. Findings showed that nurses' notions of advocacy are based on their philosophy of nursing and theory-based notions of the therapeutic relationship.

Although Snowball cautions against extrapolating too much from the findings of this exploratory study, she does consider it important to note that findings expose the nurses as holding "a philosophy of nursing which encompasses advocacy as a role responsibility both of professional practice and a personal humanity" (p. 73). Snowball's study findings also verified the assertion that the 'advocate role' is not viewed by nurses as one which furthers the profession's self-interest but rather as one which furthers

the interests of patients. Additionally, advocacy was seen as part of a collegiate endeavor which by joining nursing efforts with those of other interested parties advanced the interests of patients against what was seen by the study participants as a dominant bureaucracy.

CLINICAL ETHICISTS AND ADVOCACY

Clinical Ethics

Contemporaneously, moral philosophers have shown an interest in the notion of 'advocacy'. This interest has taken various forms, but has in the main involved a critique of the ability of assorted other disciplines to advocate. Such evaluations are also often concluded by recommendations regarding the appropriate type of advocacy for a given profession. The participants in this discourse are numerous. Among the commentaries are Daniels' (1987) discussion of 'The Ideal Advocate' on physician advocacy. In another work Jeckers (1990) provides a synthesis of the literature on physician advocacy and both categorizes the types of advocacy and highlights the one she considers most defensible. Jeckers' account was outlined earlier in this chapter.

Critiques of nursing advocacy by philosophers, and bioethicists who may or may not be philosophically grounded, also abound. Abrams (1978,1990) systematically explores

advocacy as it relates to nursing and comes to a negative conclusion about the feasibility of this as a nursing role at least within institutional settings. A clinical ethicist, Bernal (1992) also decries nurses' capacity to act as the patient's advocate. Bernal's understanding of nursing is somewhat flawed but she does pose some cogent arguments regarding the problems of advocacy.

It may be readily surmised by even the above limited account of the disputations over advocacy that it is an extremely problematic concept. Nevertheless, the fact that advocacy has been so prominent a topic illustrates the problem for individuals of meeting health care needs. Such needs are both created incidental to, and germinate inside of, the health care system. These are needs to which individuals both are susceptible and are incapable, for various reasons, of addressing themselves.

Clinical Ethicists: Professional Status

It is as a result of these and other challenges posed by unprecedented economic, technologic, and political factors that clinical ethics has emerged as an occupation over the last 20-30 years. Clinical ethics cannot in the sociological sense be deemed a profession for the reason that it does not meet most of the criteria to be so regarded. It is difficult to find consensus regarding what is the central purpose of bioethics except for the rather

circular assertion that it is to solve "bioethical problems" (Wright, 1991, p. 71).

Freedman (1989) has pointed out that there is no consensus on what the "necessary or sufficient conditions" are in order for any occupation to qualify as a profession. His is a peer request for bioethicists to consider what they are doing. To facilitate this he offers a self-conscious parsing of the tenets of his 'occupation'. "Bioethics has pretensions to saying something about practice" (p.127). Like the professions it has theory which it is attempting to apply to practice. Unlike the theories of other professions, its theories lead to conflicts regarding the purpose of action. Freedman concludes that bioethics has not yet reached professional status. However, it is evident that he thinks of clinical ethics as an "embryonic profession" (p. 126) and proposes several strategies to aid its development including the formulation of a code of ethics.

Wikler's (1991) assessment of bioethics is not so optimistic. He notes that theories in Bioethics come from different and sometimes incompatible philosophies. To this extent bioethics is unlike medicine and nursing, which have unifying philosophies at least with regard to purpose. Wikler is seeking replies to questions that may be asked about bioethicists. Examples of such questions are; What is the basis of their claim to expertise? What is the authority of their pronouncements and conclusions? He wants to know

> "is their role that of the detached expert analyst, whose personal feelings are kept out of professional work, producing a 'value free' ethics? Or are they agents of change, whose measure of success is the conversion of hearts and minds to their own notions of virtue? (p.234)

Apparently, Wikler does not think these questions have yet been adequately addressed. But he does not regard development of an overarching theory as the answer. This type of theory would have to be based an a particular philosophy and its conclusions would be "theory bound" (p. 242), acceptable that is, only to those subscribing to the underlying philosophy.

Bioethics: Conceptions and Misconceptions

Wright (1991) agrees that the field of bioethics has become 'broad' and has led to some "analyses of questionable worth" (p. 71). This is in part because many disciplines are claiming bioethics as being within their realm of expertise. According to Wright, there are two major misconceptions regarding the field of bioethics. The first is that, "because ethics is a field of study within philosophy, so too is bioethics" (p. 72). Belief in this distortion logically leads one to assume that only philosophers using philosophical strategies are the appropriate persons to solve bioethical problems.

The second misconception has to do with bioethics being a field of study concerning health care issues. This has led to an acceptance on the part of various health care professionals of the idea that "the issues are entirely circumscribed by the particular health care environment" (p. 72). This view entails that only the professional invested in the type of problem is appropriate to problem solve. For example, only physicians do "medical ethics", only nurses do "nursing ethics". These misconceptions he attributes to "misunderstanding the framework for ethical decision making" (p. 73). What results is an exclusionary view of a given problem instead of an inclusionary collaborative perspective. Wright proposes that there is a unifying perspective.

This perspective may be disseminated via teaching and be applied in practice. It requires analysis of a problem using a bioethics decision making model. The model allows input from all concerned persons. Although, the decision making model he proposes does appear to have utility especially perhaps in learning situations, it is unclear from Wright's exposition what the purpose of the bioethicist as bioethicist is except perhaps as an educator or decision making process facilitator.

As Wright has pointed out, a further concern for the bioethics community is that bioethicists are by no means all of the same background or training. Not all bioethicists are

moral philosophers "activated". Indeed Freedman has noted that it is becoming less and less common that bioethicists have an academic philosophical foundation. Such issues may be critically problematic for the development of bioethics as a profession.

In a rather scathing indictment of moral philosophers' suitability for applying theory to practice Ruth Shalit (1997) lays out her view. Her commentary appeared recently in The New Republic. In this article she argues that "in attempting to make a medical profession out of the study of what is morally right or wrong, the ethicists confuse the empirical and theoretical" (p. 24). She goes on to point out the problems with trying to develop a profession when its practice must necessarily be founded on conflicting theories of morality. For the purposes of this enterprise, though, and in agreement with part of Shalit's criticisms, I propose that one of the more worrisome aspects of bioethics concerns the danger that ethicists as employees of an institution may unwittingly be used to maintain the status quo or, worse validate questionable practices.

Unlike Shalit I do not think bioethicists are doomed to practice risk management and I think there may be a niche for them in the health care system. But it is not clear in what manner they may be patient advocates. Certainly, they do not, in general, engage in ethicist-patient relationships, nor do they base their practice on a 'code of

ethics'. As I maintained earlier and will continue to support in the course of this exposition, the notion that professions have a goal with respect to the needs of their population of concern is critical to the understanding of both professional advocacy and professional obligation.

Although, ethicists, along with perceptive others, may view themselves as obligated to advocate for someone whose rights they suspect are being infringed, it is a difficult to discover the foundation of ethicist's obligation in this regard. This is because there is not, in general a one-to-one nor a fiduciary relationship.

Ethicists trained in philosophic techniques have been instrumental in helping health care professionals become clearer about the assumptions underlying their practices. It is perhaps in this type of endeavor where the moral philosopher can provide the most assistance. However, such assistance is not limited to moral philosophy; political philosophers may also prove useful. Moral and political philosophers, it seems, may also be capable of providing assistance to society in order to help it become clearer about its implicit values and the consequences of such values operationalized in health care practices of various sorts. Therefore they may also be the discipline best suited to a higher level critique of health care delivery systems.

CHAPTER TWO

THE CONCEPT OF ADVOCACY: TYPES AND TRADITIONAL PERCEPTIONS

ADVOCACY PRELIMINARY DISTINCTIONS

Introduction

The purpose of this chapter is to make some preliminary distinctions regarding common usages of the term 'advocacy'. In the course of the analysis, 'professional advocacy' is separated from the other meanings of advocacy in order to facilitate a more discrete analysis of this concept. To support a more focused analysis of professional advocacy it is necessary to gain an understanding of the context within which professional service occurs. Professions 'profess' to be capable of providing a service to society with regard a particular good. For this reason it may prove enlightening to include a discussion of justice, because justice tells us something important about these goods. The justice arrangements in a given society are instructive regarding what goods the society values and is willing to protect individuals and groups in the possession of[20]. It is informative with regard to what it authorizes its professions to provide.

---

[20] This is assuming that the society is such that its members have some say in formulating these justice arrangements.

However, of further importance to this current enterprise is the fact that in the US the justice system exists, in part, to safeguard certain rights. The latter part of the chapter traces the notion of 'legal advocacy' as it has served as a template for 'professional advocacy' in other settings. Rights are defended by lawyers who act as advocates for their clients. The ideal of lawyers as professional advocates is crucial to the current enterprise because the term advocacy appears to have had its origin in the legal setting. Legal advocacy, then, is a form of professional advocacy; it serves throughout this project as a template for comparison with 'professional advocacy' for other disciplines.

Advocacy and Need

The concept 'advocacy' when used in association with professions and professional roles carries the implication that there exists an unmet, but potentially correctable, need or deficit on the part of another. The deficit may involve a projected or future inadequacy of some sort and/or the inability to gain a particular benefit that is determined to be a person's right under the justice system. Therefore 'advocacy' includes preventive types of action such as education and political activism. The deficit, then, may be an individual or group's lack of certain specialized knowledge which is required in order to obtain redress, or

of the skills or technology required to achieve a desired good. It could also be a deficit experienced by a fellow professional who is unwilling or unable to remedy it herself. The professional by virtue of his or her role has the capacity to provide, directly or indirectly, the expertise to address the deficit in some way. The deficiency may be at any point on a continuum from mild to severe. Consequently, the sequelae of the deficiency may range from the experience of some inconvenience to a threat to life.

'Advocacy' is a term that has been used in a variety of settings to pick out to whom the deficit is attributed, what it is a deficit of, and what other individuals or groups may be involved in causing or in remedying the need. What is less certain about 'advocacy' is both the extent to which advocates or potential advocates may be expected to discover deficits accruing to needy others and the extent (if any) and ground of responsibilities or obligations which are incurred in relation to recognition or acknowledgement of the privation. Alternatively stated, it is important to ask to whom either any remedial or any advocacy responsibilities may be assigned and for what reason. Additionally, it is vital to discover what are the philosophical foundations or assumptions undergirding any supposed obligations. For present purposes, then, it must be determined to what extent 'advocacy' is a moral concept thus requiring the action of advocates or potential advocates. For without clarity on

this issue advocacy claims on health care professionals can have little force and the expectations society has of professional service in this regard are of doubtful legitimacy.

The Scope of Advocacy as a Contemporary Concept

These uncertainties are not surprising in view of the scope of the term 'advocacy' as this relates to inadequacies of various sorts and in a myriad of settings. In order to grasp the intricacies of the notion in health care settings, though, and to clarify the problem, it is necessary to get a more basic and, perhaps, general understanding of the concept.

Historically traced definitions of 'advocacy' such as those presented in the Oxford English Dictionary (OED) (1989) note that the contemporary term 'advocacy' is derived from the 14th century French 'advocacie' which meant, "the function of an advocate; the work of advocating; pleading for or supporting" where 'advocate' is derived from the Latin 'advocatus' meaning, "one summoned or 'called to' another, esp. one called in to aid one's cause in a court of justice" (OED, 1989,p.194). A slightly expanded definition of the 'advocate' describes the role as, "one who pleads, intercedes, or speaks for, or in behalf of, another; a pleader, intercessor, defender" (OED, 1989, p. 194). A less person-oriented definition is also given. On this view the

advocate is "one who defends, maintains, publicly recommends or raises his voice in behalf of a proposal or tenet" (OED, 1989, p. 194). Accordingly, advocacy is linked both to actions by those who are supporting and promoting ideas and with actions taken on behalf of others[21].

Webster's Deluxe Unabridged Dictionary (1983), also represents advocacy as "the act of pleading for or supporting; an advocating (of something)" (p.29). The noun 'advocate' it is noted derives from the latin 'advocare' where 'ad' is a prefix for 'to' and 'vocare' means 'to call'. The advocate, then, on this traditional interpretation is one who is called to plead for or to counsel another or who "pleads the cause of another in a court of law; a counsel or counselor;" alternatively the advocate is "one who defends, vindicates, or espouses a cause by argument; one who is friendly to; an upholder a defender... of peace or of the oppressed" (Webster's, 1989, p. 29).

At least three major relatively distinct connotations may be discerned from these dictionary formulations taken together with common contemporary uses of the term. I have called these: *'aprofessional self-centered advocacy (ASA)'*,

---

[21]As James L. Nelson pointed out, these descriptions of advocacy all refer to 'semantic action'. This may seem problematic for my project, but I shall argue later that the concept 'advocacy' has been adopted from its setting in law for use in the health care domain. It is this adoption which has proved conceptually problematic for the health care professions.

'aprofessional altruistic advocacy (AAA)', and 'professional advocacy (PA)'. A discussion of each type of advocacy is undertaken in the following section.

By 'aprofessional' I mean not conceived of as emerging out of any professional-client relationship or perceived obligation thereof except in so far as this occurs incidentally; that is, not as a role expectation. By 'altruistic' I mean that the intent of the action is primarily to benefit another or others. A definition proposed by Nagel (1970) asserts that altruism is, "the willingness to act in consideration of the interests of others without the need of ulterior motives" (p. 80) and in an earlier footnote he stressed that altruism is "*any* behaviour motivated merely by the belief that someone else will benefit or avoid harm by it" (p.16, footnote 1). That is, the behavior will promote a good for the other.

The concept of altruism proves pivotal for the discussion of advocacy of the latter two categories AAA and PA. The possibility of an altruistic motivation for action is explained by the human cognitive ability to imagine being in the situation of another. As Nagel (1970) asserts, altruism arises because of this human capacity and "is connected with the conception of oneself as merely one person among others" (p. 19). It implies an ability to take at certain times either a 'personal' viewpoint, that is,to be self-aware or aware of one's personal goals and desires

as belonging in some way to self, or an 'impersonal' stance. The impersonal stance is an abstraction from the fact of oneself as 'I' to viewing oneself as a member of a society of other such selves who are also generally capable of the personal and impersonal viewpoints.

The argument Nagel presents for the plausibility of a principle of altruism is complex and it will not be discussed in detail here; however, without the possibility of altruism there can be no further discussion about the meaning of advocacy in the sense of either AAA or PA. For AAA this is an obvious conclusion but for PA it is argued later that persons enter a profession voluntarily knowing that the purpose of the profession is to promote a good of some sort on society's behalf, thereby linking their motivations to those of the profession. In general such motivations cannot be purely or even primarily self-centered or the whole meaning of 'profession' collapses. The supporting arguments for this proposition are presented in Chapter Three. Portions of Nagel's work, both on altruism and on the tension for a given individual between the personal and the impersonal standpoint (Nagel, 1991), are examined later as pertinent to the advocacy controversy.

I do not mean to rule out the possibility that although altruistic actions are carried out with the primary interest of others foremost there may be self-interested aspects. For example, I may go to visit my mother who lives some distance

away because I know she will enjoy my visit. Perhaps I cannot really afford to make the journey at present and ordinarily would postpone the trip, but she has expressed a desire to see me - so I go. This is partially altruistic in that I know it will bring my mother some pleasure and I would prefer not to go now, but it may also satisfy my self-interest in a variety of ways. For example, I enjoy visiting with her. My primary motivation, however, is to satisfy her interests.

The distinction of three categories that I have proposed regarding the concept of advocacy, then, is made predominantly on the basis of advocate intent or motivation in so far as this is determinable[22]. One motivation is primarily self-interest, the second primarily the interest of another or others. The third, which is the main thrust of this exploration, arises out of the nature of client-professional relationships and is also not primarily self-interested. Professional advocacy and its motivations, as the main focus of this study, will be discussed in more detail in chapter three.

Although I have proposed three categories, among these two perspectives are discernable. One perspective is primarily self-interested (ASA); the other perspective is

---

[22]I recognize that the motivation is not always identifiable. One can however critique an action based on what the agent professes as her primary motivation, at least in most cases.

not primarily self-interested (AAA & PA). In the first case action concerns advocating **that** a certain thing be bought, or a particular course followed, or **that** I as an individual advocating on my own behalf receive what I perceive I need. The second perspective (AAA & PA) proposes advocacy to be on behalf of another or for others.

Of the three categories proposed the first concerns advocacy that is self-regarding or advocacy **that** a certain thing occur. Unlike the second and third categories it does not postulate advocacy as those actions taken on behalf of another. It may be argued that such employments of the term are trivial and not helpful to my present purposes and in the main I agree. However, it is necessary, if the previously stated objective of this explication is to be achieved, to try and leave no stone unturned. In order to be clear about what forms or meanings of advocacy are under discussion it is necessary to outline what forms of advocacy may exist but are not the subject of the present analysis except for purposes of exclusion.

Aprofessional Self-Centered Advocacy

The first type of advocacy 'ASA' is, as I have said, prima facie the least relevant to the task at hand. This task is to uncover the ground of moral obligation to further the welfare of others in professional/client relationships. ASA, therefore, is simply per dictionary definitions to "be

in favor of" something the primary intent of which is self-interest. This category of advocacy has at least three branches.

The first branch or type 'a', concerns the promotion, support, or proposal of some service or object. The commercial gain is intended to benefit either the advocate, an employer of the advocate, or others (but not the object of the advocacy action) who stand to gain from the interaction in varying degrees. The advocacy action may, in some manner, benefit the advocacy target but since this is not the primary intent of the advocator this type of situation fits the concept of ASA[23]. On the other hand the advocacy action may prove a nuisance to the recipient of the attention. An example of this is the contemporary increase in 'telemarketing' where persons are paid to 'advocate', via telephone, a product to persons whom they have some reason to believe may be susceptible to the scheme.

Agents of telephone companies advocate in this way that one change to their brand of service, or agents of credit card companies advocate in this way that one change to, or add, the brand they are advocating. It is interesting to note that this advocacy has adversarial aspects in that one product is being advocated **against** its competitors. The distinction does however need to be made here, that the

---

[23]It corresponds to the definition of ASA proposed earlier.

advocate or the designer of the advocacy venture is hoping for a vulnerable other - vulnerable, that is, to the advocate's pitch. Any current specialized knowledge, skill or technology deficit on the part of this vulnerable other may be exploited rather than addressed or ameliorated. Indeed, even if the advocacy effort is successful it is possible the target of the advocacy effort remains unaware of any personal desires regarding the advocacy object until the act of advocacy or until the advocacy demonstration is completed. This type of advocacy then may be equated with promotion of an object or service.

The type 'a' advocate, which may be an individual, the representative of a group, or an actual group, requires an audience of some sort in order to be successful. The audience, however, has not sought the aid of the advocate. There is no form of contractual relationship existing. Susceptible or readily receptive members of the public are required for the success of the advocacy venture which attempts to create a perceived need if no previously identified need existed. It may be argued that in this day and age we do need phone service to achieve the 'good' of communication with others.

That a phone system facilitates this good is not in question. However, if the consumer has not noticed a problem to date, that is, the system works upon demand and has not caused hardship because of cost, then there cannot be said

to be a perceived need to change prior to the solicitation. It may be objected that it is in my interests to get more value for less expense. It may be granted that this is true without losing sight of the fact that the primary motivation for the transaction is still to benefit the advocate or the employer of the advocate.

For example, commercial advertisers may be inclined to advocate for the use of their product but the purpose would be in the main for their own benefit, the benefit of stockholders, or perhaps the benefit of interested others. The advocator may thus be an individual or a group. One goal of such advocacy would be to create a desire for the particular product where one did not previously exist. Another aim might be to tout the advocate's version of a product such as a chocolate bar over a competitor's.

It should be added that this notion of advocacy covers such a broad area of concerns that it is perhaps difficult to pinpoint who or what is the actual advocate in many cases. Is it those who are indirectly marketing the product or those who are actually having the interaction with the audience, or both parties? Answers to this question, and other questions regarding the moral implications of advocacy of this nature, if such are sought, will have to be found in a different forum. They are a topic of concern for those interested in exploring the nature of ethical problems that arise in business settings.

A second branch or type 'b' of self-centered advocacy also portrays the advocate as one who is in favor of others pursuing a certain course. However, this desire is secondary to some personal psychological agenda such as power, control, those seeking absolution from guilt, or validation of personal beliefs. The motivation for advocacy thus conceptualized may, of course, be either conscious or unconscious and may be difficult for both the advocate and interested others to distinguish from a more altruistic concern for the advocacy object's well-being.

Methods for discerning the primary motivation of supposedly other-oriented actions exist. These generally demand a fuller contextual picture than might be presented initially by the advocate in explanation of the advocacy. One method might consist of concerned or even disinterested others examining the present proposed advocacy action and its justification for consistency with previous such advocacy actions taken by the advocate, and for the consistency of these with the advocate's espoused belief system. Additionally, a relatively comprehensive examination of the advocacy target's circumstances should be completed where this is indicated. Nevertheless, it may prove impossible to be sure of agent motivation in certain instances.

The following may illustrate this indeterminacy. Suppose a nephew, Paul, advocates nursing home care for his

hitherto independent though eccentric elderly uncle, Bill who has been hospitalized secondary to a burn from a domestic cooking accident. He advocates it both to those charged with Bill's medical care and to Bill himself, though Bill resists. Paul's motivation may be primarily altruistic, but conversely it may be primarily self-centered. His advocacy may be aimed at providing relief from his perceived responsibility for his uncle, or may be a genuine concern for the uncle's well-being especially if he perceives Bill to be incompetent to care for himself at home. The point is that neither we nor Paul may ever know the foundation of his (Paul's) motivation. Although Paul's willingness to self-reflect and provide an account of this, together with a justification for his advocacy as being based on Bill's values, might support the claim of altruistic motivation, in the absence of such diligent appraisals we cannot know the origin of the motivation with any reasonable certainty.

The ability of humans to rationalize self-interested behavior in various ways, including that it was, or is, in the best interests of others, is well documented in the psychiatry, philosophy and sociology literature (Beauvois & Joule, 1996; Berkovitz, 1988; Bock, 1994; Brown, 1997; McLaughlin & Rorty, 1988; etc). It may well be more consistent with the uncle's life goals to remain in an independent if risky environment than to be subjected to a more regimented perhaps superficially safe environment. But

this is not the question under present investigation. Proposed mechanisms for safeguarding against the deleterious effects of advocacy of this nature, whether it is primarily altruistic or not[24], can be discovered in contemporary bioethics literature such as Buchanan and Brock's (1989), Deciding for others: The ethics of surrogate decision making, as well as in an abundance of articles from a variety of other interested disciplines.

A more intransigent problem is that of self-interested advocacy involving a wider society. I am thinking of the type of advocacy zealously undertaken by holders of certain religious or political views. The proponents of such dogmas, have an assortment of reasons why their views should also be adopted by others.

This second branch of ASA or type 'b' advocacy concerns the proposal of a particular creed or set of beliefs as being those that are in the best interests of others to adopt but does not base advocacy actions on the welfare (as far as these would be able to be determined) of those others in any definable manner. Rather, the advocacy, if successful, validates them - the advocates - in some way. Because it is not interested in welfare of others except as

---

[24]By "of this nature" I mean advocacy, the true motivation for which may be in question, but for which the articulated motivation is that it serves the best interests of another. This other, however, may be one who is deemed incompetent to decide what is or is not in his or her best interests.

notions of this welfare corresponds with the advocate's it cannot be said to meet the definition of altruism earlier proposed. It cannot be said to meet it because it is improbable that what will optimize the welfare of another can be determined in the absence of a fairly extensive grasp of an individual's life circumstances.

This type of advocacy might be thought of as 'elitist' or perhaps more arguably 'paternalistic' due to the assumption on the part of the advocate of a) a superior knowledge base regarding the advocacy situation and, b) knowledge, independent of the advocacy recipient's input, about what is best for that individual either as an individual or as a member of a group. There is no existing implicit contract or relationship between advocator and advocatee. An example of this particular version might be to vaunt a certain religious group's beliefs along with a rationalization for them as being those it would benefit everyone to adopt. It might be argued that, because it is actually for a cause, the advocacy is not really self-interested. While there is no way to prove that the action is self-interested I do not think the fact that the agent **consciously** thinks it is altruistic is sufficient for it to be so considered.

While it is true that I am arguing for the notion that some persons possess specialized knowledge and expertise that can be brought to bear to redress needs of various

sorts, I later propose that such expertise nevertheless requires knowledge about the person in whose behalf it is to be applied. Further, as we know both from experience, and as a result of psychology/sociology studies (Beauvois & Joule, 1996; Berkovitz, 1988; Bock, 1994; Brown, 1997; McLaughlin & Rorty, 1988; etc), validation for beliefs may be gained by shared expression of these with others. One way to gain shared expression is to persuade others that one's way of thinking about a subject is preferable.

It might be argued that the same problem could be posited of educators. That is, teachers persuade their students of their own views when disseminating information. As I argue in Chapter Three, a teacher's advocacy stems from professional responsibility, as do the responsibilities of other professionals. Professional responsibility involves promoting the goals of the profession - in this case the education of the students - and, therefore, should take into consideration the best interests of the student. I argue later that non-professionals may also act from altruistic motivations[25].

Finally, type 'c' ASA efforts may be instituted on one's own behalf by utilizing one's own resources and reserves to correct a shortcoming or to rectify an inequity. Advocacy in this instance seems to require the presence of certain capacities. Consider the case of Ms. Lewis a newly

---

[25]See the discussion a little later under AAA.

divorced woman who made a career move to a city several hours away from friends or relatives. She perceives that for her safety she needs a new car since the one she possesses has high mileage and is beginning to show signs of wear and tear. A new car would make her considerable travelling requirements safer. However, she knows that car dealers (type 'a' advocates) tend to be less than honest about the actual price of cars, and she has limited finances. Ms. Lewis investigates the relative merits of a variety of cars, and she obtains a book written by an ex-car salesman exposing the various tactics that can be used to hike up the price of cars thereby increasing company profits and salesman commission. She thus enters the dealership prepared to advocate for herself having remedied to the best of her ability a knowledge deficit regarding car-selling strategies.

This information-gathering has all required both effort and time. Further exertion is needed to complete the bargaining process. Without undertaking such exertion she may well have ended up either without a new car because it was not affordable, or having to do without other needed goods in order to pay for a car that cost more than its actual value. The adversarial aspect of the interaction might be noted. The auto dealer is intent on getting as much money in exchange for the car as possible; his or her commission depends upon it. Ms. Lewis has an interest in

paying the least amount possible for it which is necessarily less than that desired by the salesman.

What these three formulations of 'aprofessional self-centered advocacy' have in common is that they occur outside of any professional-client relationship or at least if type 'b' or 'elitist' advocacy is suspected to be occurring within the context of a professional/client relationship there is cause for moral concern. The moral concern is that such actions stemming as they do from self-interest will not hold the best interests of the patient foremost.

A further objection to my formulation of ASA type c is that a common usage of the term advocacy would characterize a professional who is advocating for herself in a professional capacity as practicing professional advocacy. I do not include this type of self-centered action in my analysis of professional advocacy because I wish to make and defend the distinction that professional advocacy involves the notion of obligation.

ASA types a, b, or c, then, involve self-interest of various sorts. They consist in either merely the promotion of a product, or promotion of one's own ideas, as being in the best interests of others without the concomitant discovery of pertinent factors about the lives of these others which would provide a fuller picture of what might

more truly be in their best interests[26]. The third conceptualization of ASA is concerned with promoting one's own self-interested projects. Thus for ASA, advocacy efforts, consciously or unconsciously, are aimed at meeting one's own self-interested goals. It might be challenged that in those cases of advocacy involving a company's promotion efforts the actual advocator is not necessarily the person having the most to gain. This can be conceded without the thrust of the distinction I am making proving moot. The advocator, at the very least is protecting his position with the firm and may thus be thought of as the agent of the real beneficiary and has an interest in remaining employed.

With the exception of the activity of the self-advocating individual none of the advocacy actions are predicated on the advocacy object's articulated (directly or indirectly) or observable deficit. Any challenge that the advocate of certain religious beliefs observes a deficit in the advocacy object and desires altruistically to remedy it, may be answered by pointing out that the real problem lies with the advocate whose, albeit less than conscious, motivations probably result from some sort of internal deficit of his own. But suppose we grant that there is some supernatural force at work, and that this force enables

---

[26]It might be that the ideas the type b advocate has formulated (consciously or unconsciously) regarding what may actually benefit the other, would actually benefit the other but this can't be known without discovering more about this other.

certain individuals to 'know' what is the right way to live or the right thing to do. It does not follow that we should affirm the ability of such individuals to know what it is best for others to believe or do unless they can justify their assertions based on knowledge of the advocatee. If such assertions can be so justified, then, it will have to be conceded that this may be an instance of AAA and not ASA.

For ASA, then, there may not be a deficit or need as earlier defined: that is, the lack of specialized knowledge, skills, technology, energy or power required to meet a particular goal or good on the part of the advocacy object. Any actions taken by the advocate have not arisen out of a need which is articulated by the object of the advocacy. Although the advocate may exploit or distort an individual's expression of need, the distortion is tangential to the advocate's purpose. For none of the advocacy actions is the intent purely or partially altruistic although it is possible that it seems this way to the unreflective advocate.

It may be argued, as noted earlier, that the second type of ASA advocacy, also termed 'elitist', can be appreciated also in various client-professional activities. The professional's superior grasp on the knowledge base peculiar to his or her discipline leads to the probability that a client will be susceptible to any attempted paternalistic maneuvers. And I think this objection would be

valid. However, since this 'elitist' advocacy also occurs outside of client-professional relationships, as seen in the political agendas of certain special interest groups, the distinction as made is appropriate. This type of 'elitist' advocacy is examined later in greater detail as it occurs in the context of multi-faceted conceptions of advocacy; that is as advocacy pertinent to professional-client relationships, and in particular as it has been described in legal, health care and ethics literature.

Aprofessional Altruistic Advocacy

A second conceptualization of advocacy, derived from the above dictionary sources and from other literature (Braybrooke, 1987; Nagel, 1970, 1991; Rogers, 1986) is advocacy that is neither wholly self-centered nor professionally motivated by the person or group qua professional(s). More clearly, the person advocating may be a professional but the advocacy is generally thought of not as being an expectation of the professional role but rather as a result of the fact that the professional is also a member of the community at large. As a professional the individual may have pertinent knowledge or skills which enable realization of the advocacy action but there is no explicit or implicit contractual professional/client relationship encouraging expectations of advocacy.

Rogers (1986) discusses public interest advocacy which

is an example of this type of advocacy. It is as Webster's dictionary states, "the espousing of a cause". This type of advocacy may result from community efforts to improve the lot of certain underprivileged groups within the community. It typically requires the combining of forces and resources; the more powerful with the less powerful but with the object of empowering the needy to achieve some desired end, or with the object of improving the community environment for all its members.

It shall be seen later that, at least with regard to health care, this type of advocacy may in fact be indirectly required of health care professionals in order for them to fulfil any role-based advocacy obligations. It may be so because it is conceivable that the fulfillment of perceived advocacy obligations to a particular patient requires the removal of health care policy barriers. Such barriers whether institutional or of wider scope may not be amenable to singular efforts at removal.

A further variation of AAA may be seen in the efforts of parents on behalf of children, and persons on behalf of their loved ones. Such efforts may only be considered altruistic, of course, if they fit the earlier definition of altruism. That is, the intent of any advocacy action must not be primarily self-interested.

Professional Advocacy

The third or final major conceptualization of advocacy which is derived from the above dictionary sources and advocacy literature, revolves around the notion that an individual suffers some privation or limitation and that this person does not possess either the willingness or the resources to remedy the shortfall. It is a shortfall requiring that the specialized knowledge, skills, or technology possessed by a professional or by a variety of professionals be brought to bear in order to fulfil a good for that individual. The redress actions would be aimed at furthering the individual's best interests with regard to the good in question[27]. For this reason knowledge about the person or group is usually relevant in some way to the advocacy. The individual has, though perhaps with some assistance, customarily been instrumental in seeking out the aid of the professional qua professional. Advocacy efforts would be aimed at addressing these needs in some way. It is this third conceptualization of advocacy that provides the focus for the remainder of the analysis. Although other

---

[27]In the case of persons deemed incompetent for some reason, "substituted judgement" may be utilized. Buchanan and Brock (1989) define "substituted judgement" as "acting according to what the incompetent individual, if competent would choose" (p. 10). Substituted judgement is utilized to determine what is in the person's best interest. There are occasions when either not enough is known about the person or personality traits are not stable enough to make a substituted judgement. Decision-making regarding advocacy in such cases is more problematic. Further discussion on this subject may be found in Buchanan and Brock's (1989) work.

categories of advocacy are analyzed as either pertinent or as they overlap or interact with professional advocacy.

Summary

So far, then, several facts regarding advocacy may be asserted. What is 'advocated for' results from what may loosely be termed a deficit. In category one or ASA, three main formulations may be derived: a) the perception of a deficit is created[28] by the advocacy efforts which serve primarily self-interested purposes, b) the advocacy efforts are made ostensibly on behalf of another, that is the deficit is perceived by the advocator or by forces moving the advocator to exist in the other who may or may not concur, but the motivation of the advocate is either consciously, or more probably unconsciously, self-interested, c) the advocacy efforts are made on behalf of self in order to meet a need that is recalcitrant to ordinary need satisfaction for a variety of reasons.

AAA is not professionally motivated in that it does not directly arise out of 1) the professional/client relationship or 2) the obligations of a professional to the population of her concern. It is also not primarily self-

---

[28]I mean created in the sense that the perception of the promoted object's supposed desirability was not previously grasped or acknowledged by the perceiver. Rather it is the persuasive powers of the merchandiser that 'creates' the perception of a need in this regard. Perceptions of a need can be raised by advocates in AAA and PA also.

interested. Such actions as are carried out are for the benefit of individuals or groups. They are based on individual or group interests either as articulated by these parties or as in the case of persons deemed incompetent by other pertinent standards[29]. Although AAA may result from professional knowledge about a certain instance of need, this type of advocacy is different from that incurred as a result of professional obligation[30]. Additionally, the advocacy is generally independent of considerations of the advocate's own interests although these may be indirectly served. For example, improved health care accessibility may benefit all but benefits most those least able previously to gain access.

PA or the third category of advocacy concerns advocacy actions stemming out of the professional/client relationship. The motivation for this is also not primarily self-interested but arises out of the special relationship between the two parties. Most of the categories of advocacy exhibit moral aspects of varying sorts.

The moral concerns raised are dependent on the category of advocacy under discussion. A good example of moral content pertinent to ASA type a, or commercial self-centered advocacy, may be tobacco advertising campaigns aimed at encouraging teenage smoking. Advocacy of the product in this

---

[29]See the footnote #27.

[30]See Chapters Three and Four for an elucidation of PA.

way may benefit a variety of interested parties; tobacco growers, vendors, stockholders and such to the detriment of others and can be aimed at removing barriers to the commercial enterprise thereby increasing personal gain. One example of a barrier to the commercial enterprise of increasing cigarette sales is teenage disinterest in smoking. Another is the publicization of health risks. For type a there may be situations where such advocacy is morally neutral or is permissible. For example, a billboard that brings to the weary traveller's attention the presence of a nearby hotel might be considered morally permissible. Although it could also be claimed that such billboards are not aesthetically pleasing.

'Elitist' advocacy or ASA type b also has moral aspects which deserve (and have in the past received) philosophical and political attention. The reason that ASA type b may prove problematic to the targets of such advocacy have to do with liberal notions regarding the nature of human beings. The ideas of philosophers such as Locke, Kant, Bentham and Mill among others have contributed to the various conceptions of liberalism (Russell, 1945, 1972). In general the liberal tradition proposes the notion that "all men are born equal" (Russell, 1945, 1972, p. 726). This equality has more to do with moral status as human beings rather than intellectual capacity. The idea is that in general persons have the capacity for self-determination.

Contemporary liberal views allow for the fact that persons may not be born equal in physical or mental advantage but that in so far as they are human they possess equality with respect to rights that are accorded other humans in virtue of their humanity. This view entails the notion that barring physical or mental aberrations which would militate otherwise, persons have a right to be free from the coercive influence of others. There are constraints on this freedom if one's actions would pose either a harm to others, or in some significant way a harm to one's self. This latter constraint requires strong justification of the necessity; the harm has to be serious (Wikler, 1983, p.84). An example of a significant harm to self is suicide.

For type c of ASA, where there is a perceived deficit on the part of an individual who wishes to remedy this shortcoming solely for self-interested reasons and is possessed of the wherewithal to advocate for self, the moral link is seen in terms of what rights may have been violated and what obligations may be demanded of the violator under either the societal justice system or as a result of conceptions regarding moral permissibility. There would be additional constraints against harming vulnerable others in the course of the advocacy actions.

The important distinction between this and AAA or PA is that, at least initially, there is no middle person acting as an advocate. If this condition should change and an

intermediary in the form of a professional is sought, then, ASA type c defaults to PA.

The second classification of advocacy 'aprofessional altruistic advocacy' is perhaps more difficult. It is so because the need, which has led to an assumption that advocacy is necessary, may be more incorrigible. That is, the individual or group with the need may not be in command of the resources to correct the shortcoming. Such lack of resources requires that either the need remains unrelieved or that the actions of resourceful others in behalf of, or together with, the needy are forthcoming. There are, of course, intricate moral problems posed by societal inequities. I do not propose to totally ignore such problems but rather to examine them as they arise in the context of intersections between 'aprofessional altruistic advocacy' and 'professional advocacy'.

The third conceptualization of advocacy 'professional advocacy', or that advocacy that has been assumed to arise out of the nature of professional client relationships, is the main focus of the investigation from this point on. However, questions remain about the part altruism plays in PA. Such questions are investigated further as they arise. From this point on then the focus of the inquiry is to clarify the moral foundations of professional obligation.

Confusion regarding moral foundations can lead to, or maintain the current problems of communication between

disciplines. Inconsistent use of the term 'advocacy' also creates barriers to understanding what the limits of obligations may be for the various professional groups. It is only by coming to grips with such disparities of interpretation that any hope of meaningful interdisciplinary communication can be realized. And it is only by achieving clarity of meaning in this regard that society can be made aware of the scope and limits of the advocacy actions that can be expected of professionals qua professionals. Finally, then, the proper scope of professional versus individual accountability can be uncovered.

ADVOCACY: AID TO ANOTHER

Justice and Society

Thus far the distinction made between the categories of advocacy has rested upon agent motivation, with regard to whom the advocacy action is to benefit. Only in AAA and PA is there a perceived moral obligation to advocate. I mean 'moral obligation' in the sense that gives the potential advocate a reason to aid another or others to achieve a good. The reason in the case of AAA would be "purely moral" in the sense of stemming from internal sanctions. These internal-to-the-advocate sanctions motivate her to actions aimed at achievement of whatever good is perceived as being required.

In the case of PA reasons for action may emanate from

the externally imposed rules of professional conduct mixed with more personal or internal values. Personal or internal values often serve as mediators regarding how rules of professional conduct are to be interpreted. For example, Plank Five of the American Nurses Association Code for Nurses (1985) asserts, "The nurse maintains competence in nursing" but how competence is defined by the individual nurse may be vastly variable from someone who fulfills minimum legislated requirements such as continuing education units and licensure, to one who is always striving for further professional development.

In PA the advocacy furthers the particular good that the profession exists to promote. For example, the main goal of medicine is cure of disease or, perhaps more broadly conceptualized, health. PA concerns facilitating the removal of obstacles of various sorts or by supplying the wherewithal to remedy need with regard to the good in question. Additionally, the potential advocate may experience a drive or push to advocate for reasons that are not primarily self-interested. Pertinent goods are those determined by a society, or perhaps by the potential subject of an advocacy action, as necessary for well-being.

The provision of goods, when these are deemed by the society as vital for the well-being of individuals in the society, are generally safeguarded for individuals in some way. By 'safeguarded' I mean that there is a system in place

to facilitate those individuals who are lacking in some measure with regard to the particular good, in gaining access to it. By 'vital' I mean critical to some sort of meaningful life.

In a democratic type of society, those goods deemed crucial for furthering the ideals of the society are safeguarded via some sort of legislative system. The society may, of course, value additional goods that it is not willing to constrain the distribution of. The legislative system determines in what manner and to what extent people will be legally protected from having their rights to these crucial goods violated. The justice system for a given society oversees the process of rights protections for individuals and groups.

The term 'justice' is, of course subject to ambiguity of meaning as is 'well-being' but the two are connected. As I have noted, the individual (in a society that recognizes rights) is said to have rights with regard to certain goods deemed crucial for the furtherance of the ideals of the society. I am going to assume as given that ideals or values are not necessarily static, although some may be. There is no way to guarantee that all societies will value the same goods to the extent of legally securing them for persons, nor even that the same society will continue valuing the same goods over time. What is true with regard to the rights of individuals in a particular society at a given time is

likewise subject to a variety of changes. This is not, however, to deny the possibility of criticizing a given society's system of values or rights.

Assessing a Societal Value System

Indeed, in order to be considered at least temporarily valid as an expression of a given society's ideals, a society's set of values should meet the minimum criteria of coherency; that is, there should be evidence of meaningful connection between verbal or other media expression of societal values, and visible actions or policy implementation; and relative consistency, in that relatively similar situations are subject to relatively similar treatment. Additionally, the justification for actions taken or proposed should exhibit a certain amount of logical consistency. That is, the rationale given includes a conclusion that is either entailed or supported by the premises.

One further criterion which might assist in assessing the value set of a system is that an individual not be especially disadvantaged in the society by purely accidental characteristics such as being female, or perhaps by having origins in another culture/society. Rawls (1971) describes such a standard in his Theory of Justice. His theoretical framework, which culminates in the postulation that particular principles of justice would be proposed under

specified circumstances, builds upon the conception that principles of justice appropriate for that society would be those chosen by hypothetical though "rational and mutually disinterested" persons who deliberate behind a "veil of ignorance" (Rawls, 1971, p. 51).

The crucial point for our purposes is that such persons would have to choose the rules of justice without knowing how they personally would actually stand to either benefit or be harmed by them. Therefore, what would be agreed upon would ensure that any disadvantages incurred by the rules would be those which benefit everyone and would benefit the least advantaged most. Part (a) of the second principle of justice asserts that "social and economic inequalities are to be arranged so that they are ... to the greatest benefit of the least advantaged, consistent with the just savings principle" (Rawls, 1971, p. 302).

There are criticisms regarding the ability of the 'veil of ignorance' to achieve what Rawls has proposed. Miller (1980) has undertaken a critique of Rawls' Theory of Justice. Rawls' has as a "criterion of social justice, the...difference principle" (p. 81). According to Miller the difference principle is problematic. It essentially asserts that "basic institutions ought to maximize the life prospects of the worst off" (Miller, 1980, p. 81) and that persons deliberating behind a 'veil of ignorance' would affirm this principle. Miller thinks this is not necessarily

the outcome of such deliberation; it is not, because what Rawls has not taken into sufficient account is certain factors about human nature, especially human nature under less than ideal conditions (Miller, 1980, p.82). However, persons in the original position do have this knowledge as Rawls himself tells us, thus they may not affirm Rawls' conclusion.

My inclusion of the idea of a 'veil of ignorance', therefore, should not be taken as a blanket endorsement of Rawls' view. I merely wish to point out that there are a variety of philosophical approaches to critiquing a society's values, and that the purpose of such critiques is to assess both what goods are valued as crucial to the well-being of societal members and how strictly these goods are protected for citizens.

The critique of a society's values would, then, include testing for all of the above characteristics: coherency, general consistency, logical consistency (where this is able to be determined). Additionally, there should be some sort of mechanism for ensuring that the concerns of different groups in the society, including the disadvantaged[31] are heard and addressed.

Implicit and Explicit Values

I use these characteristics as a gauge to assist in

---

[31]In whatever way they may be disadvantaged.

fulfilling at least one of the purposes of this particular exposition, which as noted earlier, is to clarify some implicit and explicit values underlying health care provision in the United States and to examine them for congruency. This is necessary in order to achieve efficiency of health care delivery to the people in this society based on its own explicit values as expounded in The Declaration of Independence and presently upheld in the Constitution of The United States of America.

If the implicit and explicit values are not congruent, then professionals who are striving to operate on explicit values will be frustrated in their efforts; and their clients will be confused and misled in their expectations of such professionals. It is my contention that professionals must be willing to expose implicit values in a society when there is apparent conflict between these and explicit values in order that they may be challenged. This point proves important for the later discussion which focuses on the tension that is present when advocacy of an individual may be in opposition to the needs of the larger society. If implicit values survive the challenge they will have undergone conversion to explicit values; that is, they will have become widely and openly articulated values, and may thus be compared with existing explicit values for congruency.

The Structure of Justice

It is worthy of reiteration that not all societies conform to US or other similar Western views of justice. For example, it is questionable to what extent a country such as Japan would find Rawlsian notions of 'rational self-interest' (Rawls, 1971) helpful in solving justice questions. Japan has traditionally been less focused on individuality and more on facilitating the good for the group or community which is seen as a cohesive unit. Jack and Jack (1989) emphasize that the law is a social construct which reflects dominant cultural beliefs" (p. 20). The law is not, however, necessarily equivalent to justice[32].

Various philosophers from ancient to contemporary times have supported this view, contemporaneously proposed by Jack and Jack, of the structure of law as this is viewed as being a particular society's formalized system of justice. Alternate stances include the notion that the tenets of justice are derived from divinely revealed laws or from natural law; that is, they are derived either from the belief that the laws of nature, and thus morality, are divinely created/inspired, or from the idea that because the laws of nature are stable and unchanging it therefore follows that moral rules are likewise stable and unchanging. The role of humans under such conditions is to discover what these moral rules are that they may act morally.

---

[32]See the later quote from Jack and Jack.

One of the problems, according the Jack and Jack (1989), with justice systems which are built on implicit or explicit social contracts is that non-dominant cultures within the dominant culture may not "find their aspirations and world views mirrored there" (p.21). This is a difficult problem in the sense that a non-dominant culture may nevertheless consist in a substantially large number of people - it may even be the majority. Take for instance the policy of 'Apartheid' in South Africa which disenfranchised the majority culture.

Justice in the United States

The present justice system of the USA has had a variety of influences in its development. Its formation was mostly inspired by the British justice system but with modifications that reflect alignment with US constitutional ideals. Certain "self-evident" premises are foundational and defense of individual rights is upheld as a core purpose. Lawyers represent a given client as that client's legal advocate. What this requires is epitomized in a well quoted oratory by Lord Brougham as he was defending Queen Caroline in her divorce case against her husband King George IV. Brougham claims that,

> an advocate, in discharge of his duty, knows but one person in all the world, and that person is his client. To save that client by all means and expedients, and at

> all hazards and costs to other persons, and, amongst them, to himself, is his first and only duty; and in performing his duty he must not regard the alarm, the torments, the destruction which he may bring upon others. (Freedman, 1975, p. 9)

It might be questioned whether this is really how contemporary lawyers view their obligations. As I shall show this is one conceptualization of the lawyers role; there are other less narrow views.

Lawyers as Advocates

US lawyers, when acting as legal advocates for clients have a well-recognized responsibility to represent their client's interests or to defend the client's rights apparently to the exclusion of consideration of the interests of others. Canon 15 of the American Bar Association Canons of Professional Ethics (1908) confirms that "the lawyer owes entire devotion to the interest of the client, warm zeal in the maintenance and defense of his rights and the exertion of his utmost learning and ability..." on the client's behalf. This advocacy is founded on the ideal of autonomy in so far as the client is an individual who is accorded rights by society which the lawyer as advocate is to defend. As the American Bar Association (ABA.) Model Rules of Professional Conduct (1980) observes, "Almost without exception, clients come to

lawyers in order to determine what their rights are" (Rule 1.6). The American legal system as one of

> rights and duties is expressed in rules and promotes adversary relationships between theoretically autonomous and legally equal people. Institutions and individuals compete to assert their rights and resist the imposition of obligation by others. (Jack & Jack, 1989, p. 22)

The lawyer as the advocate of a client is seen as having responsibility solely to the client although there are sanctions against certain practices such as lying.

Such exclusivity of responsibility has given rise to certain criticisms regarding the moral defensibility of legal advocacy. For example, in order to properly defend a client a lawyer is apparently justified in publicly denigrating the client's opponent. Public denunciation of a person's character can damage much more than the individual's pride. The legal advocacy role is an adversarial one; it pits lawyer as client representative against the client's opponent who may in turn be represented by an advocate. Schaffer and Cochran (1994) note of this "functional view of partisan advocacy" that although it has had its place in rectifying civil injustices "it tends to ignore the effects that advocacy at its best, has on the parties and on other people" (p. 11). They propose that although there is a place for "aggressive advocacy" it does

not follow just from this that it is "routinely appropriate" nor that "aggressive advocacy can be pursued with a moral license to harm other people" (p.11).

The Adversarial Nature of Anglo-American Justice

Loh (1984) describes the purpose of the adversarial nature of the Anglo-American judicial procedure as follows: "The premise is that each side will exert effort to present its case in the strongest possible light, and from this partisan confrontation, truth will eventually emerge and justice will be served" (p. 34). The lawyer's actions on behalf of her client, no matter how destructive to others, are seen as justified by the lawyers creed as set out in The American Bar Association Canons of Professional Ethics. These are thought to protect the advocate in pursuit of her client's interests. Like other codes of ethics the language is somewhat general and non-specific leaving room for interpretation.

Jack and Jack (1989) note that the lawyer's role, at least as traditionally conceived involves the assumption of characteristics of: "partisanship, neutrality, and moral distance" (27). The partisanship is exemplified by the above example of Lord Brougham's view of the advocate.

Neutrality is explained as the representation of a client "without passing judgement on the character of the client or on the moral merits of the clients position" (Jack

& Jack, 1989, p. 32). The neutrality is only assured once the lawyer has undertaken to represent the client. That is, up to the point of acceptance of the case there is a choice to be made by the professional. The choice may be made on moral grounds and/or on practical considerations whether or not to represent the client.

Moral distancing occurs because "Partisanship and neutrality delimit the moral world of a lawyer and focus almost exclusive attention on client concerns" (Jack and Jack, 1989, p.34). The term 'moral world' signifies the special behaviors or attitudes expected of a professional when acting in a professional capacity. Such behaviors may run contrary to personal values and attitudes. For this reason the lawyer may have to distance herself from her personal values in order to provide client advocacy.

Criticisms of the Legal Advocate Role

However, surrendering one's personal values, in the undertaking of a representation, on the premise that this is what the role demands may also pose problems of what existentialists such as Heidegger and Sartre call 'authenticity' for the agent. Authenticity requires the person to be aware of him or herself as an individual capable of making choices for self. Although this point may seem irrelevant to discussions of professional role or activity with regard to the interests of the client, it is

not. Making choices as 'authentic'[33] self also includes 'authentic' interaction with others.

Role-differentiation as described by Goldman (1980) and Wasserstrom (1986) seems to require acting inauthentically. Role-differentiation is the proposal that "those in professional roles require special norms and principles to guide their well-intentioned conduct" (Goldman, 1980, p.1). Thus role-differentiation allows or even demands of the professional that she "weigh less heavily what would otherwise be morally overriding considerations" (p.4). It also commits the professional to elevating the interests of those with whom she has a professional relationship over all other interests even if this would violate the rights of those others. That is, it seems to require acting as what Heidegger (1962/1927) calls "they". The importance of this is that while in the 'they' mode an individual is not in fact individuated in the sense of being conscious that actions undertaken are the result of choices made by that agent. Thus one problem for professionals acting in a role-differentiated manner is that it seems to demand a suppression of the self in some way; it does so because what is demanded is that the professional act otherwise than they would ordinarily do or than would ordinarily be permissible.

Professionally exercised moral distance is subject to

---

[33]James L. Nelson reminded me that this notion regarding 'authenticity' is similar to, if not synonymous with, notions of integrity.

other criticisms especially with regard to the legal advocate function. Wasserstrom (1986) in a critique of the role of lawyers as professionals notes "the lawyer is vulnerable to some moral criticism that does not as readily or as easily attach to any other professional" (p. 114). That is, the legal advocate role often requires ignoring moral concerns that would in any other situation be pivotal to decision making regarding what action or stance to take. The adversary system, as William Simon (1986) explains, thus facilitates the lawyer in "his explicit refusal to be bound by personal and social norms which he considers binding on others" (pp. 216-17).

Such narrowness of focus allows the advocate to carry out his activities without suffering from the moral unease that occurs in "the moral world of ordinary life" (Wasserstrom, 1986, p. 119). Wasserstrom (1986) has other criticisms. One of these focuses on the unequal nature of any type of professional/client relationship. This inequality can prove problematic to the client. The client is not generally in a good position to evaluate the lawyer's advice or expertise. The professional is, therefore, in a position of power relative to the client which tends to incline the advocate to treat the client like a child.

Wasserstrom asserts it to be true of any professional/client relationship that the inequality of knowledge/power facilitates the objectification of the less

knowledgeable client. It facilitates it, on Wasserstrom's view because not only is the client seen as not having the necessary expertise, even if she did possess this expertise she is considered "to lack the objectivity required to utilize that competence effectively on ... her own behalf" (Wasserstrom, 1989, p.93). Therefore the client is treated with less than the respect deserved by individuals.

Further, because the professional is generally only interested in that part of the person requiring the professional's specialist knowledge, there is a tendency to view the client in a less than holistic way. Wasserstrom (1986) gives examples of this, he writes that, "at best the client is viewed ... not as a whole person but as a segment or aspect of a person - an interesting kidney problem, a routine marijuana possession case" (p.128) or perhaps a player in an interesting ethical dilemma. Such relationships, then, he finds morally problematic for a variety of reasons.

One problem for clients, though, concerns the tendency towards paternalism in professional-client relationships. This issue and the problems surrounding notions of role-differentiation for professionals are analyzed further as these relate both to the legal and to the health care professional-relationship. However, an important factor concerning paternalism is that society, by the high esteem it has traditionally accorded to the various professionals,

tends to reinforce the professional's exalted view of his or her abilities. The risk here is that the professional will exhibit a paternalistic attitude towards the supplicant when this is not warranted. Paternalistic attitudes tempt the professional only to disclose what he or she thinks will give the best result or address the client's best interests thereby further depriving the individual of adequately informed decision making power. Ironically, then, zealous advocacy, one of the functions of which is to promote the ideal of autonomy or respect for individuals as individuals, often actually undermines that distinction.

Wasserstrom (1986) recognizes the difficulties to be encountered in attempting to address the problems of professional/client relationships in general and lawyer/client relationships in particular. One solution he proposes involves the deprofessionalization of the professions although he concedes that this is a difficult problem requiring further study. Professional/client difficulties as presented above are analyzed in more detail in Chapter Three. Meanwhile, several commentators have suggested improved communication with less use of specialist language as a way out, in addition to wider education of consumers.

Criticisms of the Adversary Nature of the Justice System

The US justice system has as a premise the idea that

the adversarial method may be relied upon to reveal the truth in conflict situations. This adversarial nature of the system has been criticized. Scholars from a variety of disciplines have questioned every aspect, from the notion of lawyer as " 'pure legal advocate'... in which a good lawyer does not satisfy our criteria of a morally good person" (Cohen, 1988, p. 30), to the fundamental underlying premise that there is some sort of objective truth that can emerge in adversarial engagements (Menkel-Meadow, 1996). Further, Menkel-Meadow (1996) a law professor, contends that "the binary nature of the structure of the adversary system and the particular methods and tactics of its use in the legal system may often thwart some of the essential goals of the legal system" (p. 49). In support of this claim she argues that such antagonistic approaches to conflict settlement aren't able to get at the full story. They don't accurately address complex problems and they tend to escalate emotions thereby worsening the dispute. These are a few among other equally pressing concerns she expresses.

Even if the adversary system were to be appropriate for some cases, and she is not convinced of this, she notes that the adversarial attitude seeps in to other negotiational types of legal work. At fault, she asserts, are the foundational assumptions of the adversary system which have not been seriously examined. Among these are "objectivity, neutrality, argument by opposition and refutation, appeals

to common and shared values and fairness" which "have all been questioned by modern scholars outside of (as well as inside) law" (Menkel-Meadow, 1996, p. 51). I discuss such disputes regarding the structure and nature of the legal system and its professionals as they are seen to be cogent to this concept clarification project.

Advocacy: Legal Versus Other Professions

An analysis of the demands (or lack thereof) that legal advocacy places on its practitioners, provides a lens through which to examine the moral implications of the various advocacy assertions of other disciplines. Additionally, advocacy talk within the various health professions is generally supposed to have its origins in the notion of legal rights advocacy. It is perhaps not surprising, then, that claims to advocacy ability on the part of professionals such as nurses are met with some incredulity. If it is believed that a nurse's advocacy role is merely to preserve rights but without the protections afforded lawyers in their roles, even if such protections ought to be challenged, then it will be believed that she is doomed to fail as are all other such unprotected professionals.

For, whereas the lawyer has by virtue of her adversarial role, while advocating, abdicated her

responsibility to the larger society [34] (although as we have seen this may be problematic), health care professionals are accorded no such luxury. The tension between the interests of the larger society and those of the individual are complicated by the dependency of both types of interests on each other. By this I mean that the interests of the individual will not be furthered in an environment that does not value the individuality of persons. But an environment that does not try to ensure that the interests of as many individuals as possible are secured will be unlikely to ensure the interests of individuals.

Stated another way the dilemma is this: a society which focuses on the rights of its individual constituents and on the defense of those individual rights, can, if it does not scrupulously guard against these problems, facilitate problems of inequality of opportunity, or of access. By concentrating on the safeguarding of individual rights it may compromise the welfare of the larger community. But concentration on the welfare of the community in general can lead to neglect of individual rights. It is continual attention to and awareness of the tension or balance between these two foci, what Nagel (1970) has termed the "personal" versus "impersonal", or what others have called partial versus impartial or universal, that is crucial to the

---

[34] That is, except in the sense of the advocacy system serving individuals who are societal members.

continued well-being of a society.

It may well be asked what would comprise the well-being of a society. Once again, there are no ready answers to such questions but societies should minimally be held to observable movement towards fulfillment of their own conception of this if this conception passes the coherency test. The coherency test, especially if some constraint is used to prevent the especial disadvantaging of certain individuals or groups, should allow criticism of a given society for not making observable movement to fulfil its own conception of what constitutes well-being. Support for US conceptions regarding the minimum conditions of well-being, may be found both in the Declaration of Independence and in its own constitution.

Additionally, it is my thesis that there is a link between the problems of non-dominant or disempowered groups in the US justice system (those least likely to be able to insist on respect for their individual rights) and the problems of such groups in achieving justice from the US health care delivery system.

The focus on individual rights in the United States justice system has led to an adversarial system of defense. The lawyer defends her client with respect to client rights. The action is one of advocacy. The concept advocacy as used by health care professionals undoubtably has its origins in this notion of legal advocacy. The concept, however, has

evolved in meaning depending on the context of its employment, or on its implications for professional conduct in a variety of settings. Some alternate conceptions of advocacy were discussed in Chapter One. These remain to be analyzed further.

Professional Advocacy, then, can be said minimally to be certain actions taken out of a perceived obligation to another or to others and occurs within and as a result of the professional/client relationship. It has its origins in the legal adversary system but has broadened in meaning depending on the context of its use. Even on its narrowest interpretation there are obligations imposed on those professionals who claim an advocacy role in view of the nature of the relationship between professional and client. These obligations arise either out of implicit or explicit contractual relationships between professionals and their clients or client groups, or out of the relationship between professionals and the society of which they may be at least loosely[35] described as members. As described briefly in Chapter One the need for the assistance of another arises for a variety of reasons.

---

[35]I say loosely in answer to the objection that some professionals work across cultural borders. One such group is 'Doctors Without Frontiers'.

CHAPTER THREE

PROFESSIONAL ADVOCACY

INTRODUCTION

Overview

An investigation into the meaning of professional advocacy is best carried out within the context of the larger quest which seeks to exhume the nature and foundations of professional obligations. This is so because an understanding is needed, however tenuous, of the boundaries of obligations which link to professional role if we are to make sense of the notion of advocacy as a duty. And if there are no grounds for attaching any responsibilities to the role of a given practitioner then the notion of professional advocacy may prove to be illusory. Of course, it could turn out that advocacy is never particularly required of the professional, but proof of this also demands an inquiry into professional obligation.

This chapter, then, investigates the nature and foundations of professional obligations. In the process the link between professional advocacy and professional obligation is uncovered. The mechanism by which codes of ethics for professions are formulated is investigated because this provides several insights. These insights include: the founding assumptions of the profession, the

profession's promises to society, the evolution of promises in response to changing societal expectations of professions and consequently of a profession's membership.

The second section of this chapter considers, then rejects, the idea that professionals enjoy a different moral status than do non-professionals. It addresses the question: "should members of a profession be held to a different standard of moral conduct than other citizens?" This question proved important to address since, as Wasserstrom notes, some commentators seem to be suggesting that certain types of professionals by virtue of their professional roles are immune from moral criticism that would obtain for the rest of society (Wasserstrom, 1986, 114-142). While I reject this view of a different ethical status for certain professionals I do recognize that a stronger obligation exists for members of a profession to uphold the goals of that profession than exists for non-members. The stronger obligation arises from the professional's voluntary commitment to the goals of the profession which is made upon gaining membership to the profession.

This less radical interpretation of the different moral obligations which seems to exist for certain professionals supports the idea that the 'functional' view of professional role is mistaken, as I shall show. For most professions the commitment is to the population of concern for that profession. Consequently, there is in general a close

relationship between the goals of the profession and the goals of the society.

The third section argues that professional advocacy is the professional role. It becomes important to make comparisons between the role of professional advocacy for legal representatives and the role of professional advocacy for health care professionals. It is as a result of a conflation of the meaning of advocacy in legal settings with that of advocacy in health care settings that confusions have arisen. Health care professional advocacy is asserted to be broader in scope than legal advocacy since it involves not only advocating for an individual but also advocating for societal change when this is what is required to further the goal of health for an individual, group, or society. This assertion is borne out by the 'codes of ethics' of nursing, medicine and other health care disciplines such as social work, dentistry, psychology. The broader scope of the obligation poses additional problems for health care professionals that are not typically presented to legal professionals.

Claims

The extent of a professional's responsibilities, then, to the population, or members of the population, of his or her profession's concern will be dependent upon one or more of the following: 1) The claims that can be validly made by

an individual or group on the professional in virtue of her membership in a particular profession and/or, 2) what the profession as a whole asserts to be its responsibilities toward individuals and towards the larger society. But a further consideration is, 3) the degree to which such responsibilities as either traditionally undertaken by, or traditionally assigned (at least implicitly) to, the profession by society remain feasible under changing societal circumstances. These three components are the focus of study in the first part of this chapter. The latter part of the chapter is devoted to an in depth exploration of professional advocacy as it is understood by both nursing and medicine.

FOUNDATIONS OF PROFESSIONAL ETHICS

Elements

Camenisch (1983) proposes that when discussing the "grounds or foundations" (p.2) of professional ethics it is important to consider three linked elements. One element concerns the origin of any supposed moral framework of the profession. The second consideration questions what "authority" the moral tenets of this framework carry; it concerns asking "why professions and professionals should feel obligated to observe them" (Camenisch, 1983, p.2.). Lastly, one must be aware of the most "general *content* of the governing norms and values of professional ethics, of

those standards which come to bear on a professional just by virtue of their presenting themselves as such, even before they specify which profession they refer to" (p. 3). A large part of the answer to all three questions involves an extrapolation from the norms and values of the pertinent society.

Although professional obligations are predicated in some way on the norms and values of the larger society it does not follow that the larger society has a direct voice in formulating professional norms[36]. This important insight into the issue of professional obligation is provided by Pellegrino (1982) who draws attention to the fact that because professions typically guard their ownership of specialized knowledge, society isn't directly involved in the dialectic regarding the particulars of a given profession's responsibilities to the public. This lack of democratic debate has a tendency to lead to misunderstanding and mistrust of professional activity.

Professional Codes

Professional actions are typically guided by codes of ethics formulated by the profession and which describe expectations of professional activity. Such codes are

---

[36]It may prove important for the public to have a more direct dialog with the professions in regard to professional assertions because of potential constraints on professional actions caused by the current health care delivery environment. I re-examine this point later in the project.

supposed to address the needs of the society sanctioning the profession and its activities. It is, however, arguable to what extent professional activity can be said to be sanctioned by a society whose ordinary members aren't given voice in the debate. Although changes in society's values are considered by those making, and may even catalyze, revisions in a profession's code of ethics, the impetus for such revisions remains the profession's reaction to societal change.

The stimuli for correction in professional guidelines have debatable origins ranging from the profession's self-interest to genuine concern for the public's interests. Further discussion regarding a profession's evolutionary motivation is important and it does make a difference whether this motivation is benevolent or self-serving. I will examine the tenets of various codes presently for insights into what are the professional promises to individuals and society. At present it is sufficient to note that, 'codes' are reflective of the attitudes of the professionals rather than, or at least not directly, those of the public.

Professional Accountability

Lisa Newton (1988), a philosopher, has also provided an account of the relationship between professions and professional codes of ethics. To facilitate her argument she

furnishes three characteristics foundational to a group's acknowledgement as a profession. These characteristics might be thought of as minimum criteria allowing individual members of the profession to be validly described as "fully professional" (Newton, 1988, p. 48) members of an aggregate which is entitled to the designation 'profession'. The characteristics are those evidenced by individual members who together constitute the group. For the three elements to be present it must be able to be asserted of such persons that:

> 1. They possess a specialized art, skill or capacity, requiring long and difficult education and extended practice; 2. They are employed full-time in the practice of that art, entailing[37] that the art is practiced for pay; 3. Individually and/or collectively, they render a service to individual clients and to society in the practice of the art. (Newton, 1988, p.48)

It is recognized that individual professionals may to a greater or lesser degree exhibit these traits, however, they will be present in general. Additionally, the codes of conduct of the various disciplines provide more clues to the specific values of the profession and, though to varying

---

[37]This appears to rule out the possibility of independently wealthy professionals. However, Newton is talking about the profession as an aggregate, thus, this statement may in general be true.

degrees, of individual practitioners.

Newton discusses each of the above three facets in more detail, but what is most important for present intentions relates to the third characteristic. Although criterion three is broad, among the understandings which may be drawn from it is the fact of professional accountability. Such accountability means that the professional in the course of interactions with societal members "comprehends both the person ultimately served and the knowledge essential to the service in his perception of his obligations" (Newton, 1988, p.48). Newton's point here is to highlight the fact of the individual practitioner's responsibilities to acknowledge these acts of service including the ultimate effects of them "upon individuals and society" (Newton, 1988, p. 49) as her own. This demarcates a professional from a "craftsman, who is responsible only for turning out a technically good product" (Newton, 1988, p. 49); thus seeming to require less stringent moral guidelines, perhaps for the reason that continuation in the practice of the craft requires either the success of the product or the personal satisfaction that creativity brings. Newton admits that the project of trying to isolate what is distinctive about the professions is tricky, but she concludes that it may revolve around the notion that there is a process of service which appears to demand more of the professional.

Autonomy and Accountability

The accountability norm in turn presupposes a certain autonomy. For if the professional is not free to implement necessary services it does not make sense to hold her accountable either for the quality or for the failure to provide such service. For example, if a physician knows that a certain drug, though expensive, is the best one for this particular patient based on history and physical examination data, but the patient's managed care company will not sanction it, then the physician's autonomy to provide the service is truncated. The notion of autonomy for professionals is taken up later. However, if the professional cannot be held to some degree accountable for the service rendered then the ideal of professional obligation is obsolete.

The purpose of distinguishing professionals from craftsmen this way is to bring out the notion that for the professional there is an inclusive view of what professional service entails; that is, of what Newton terms the 'process' of service which is an enterprise of greater complexity than that of the craftsman. The professional's extensive education and training is crucial for the service process.

> The professional must respond ... if practices in his field are inadequate at any stage of the rendering of the service: if the client the ultimate consumer is unhappy; if he is happy, but unknowing, badly served by

> shabby products or service; or if he is happy and well served by the best available product but the state of the art is not adequate to his real needs. (Newton, 1988, p.49).

More will be said about this later. But what is significant to our present debate is that on Newton's view it is within the professional's purview, as a result of the professional's possession of specialized knowledge, to recognize and anticipate problems blocking furtherance of the profession's purpose. These obstacles may go unheeded by the non-professional or client. They may go unheeded for several reasons: 1) Because there is a lack of recognition and/or knowledge that a problem exists actually or potentially, 2) because there is a lack of recognition that unaddressed problems are harmful in some way, 3) the client does not grasp what is required in order to promote the goal of the profession with regard to society[38].

The Formulation of Professional Codes

Perhaps even more critical for the current project is Newton's (1988) discussion of the development of codes of ethics for the professions. She notes that of rules which govern professional conduct there are two related but

---

[38]The problem for the client is that she may not recognize to what extent her realization of individual goals are bound up in the profession's goals. This poses problems if the profession does not get support in trying to realize these goals.

distinct aspects which she terms 'internal' and 'external'. The internal aspect stems from the beliefs and values of individual practitioners. As such, it has a tendency to be somewhat rudimentary, subjective, inconsistent and charged with emotion. An example of an element of the internal aspect might be a sensitivity to the suffering of others which culminates in a desire to learn ways to alleviate such suffering. If this is coupled with a belief in the value of making a contribution in some way to society it might well direct the individual toward a health care career. The foundations of such beliefs and desires are no doubt complex. Nevertheless, it is this set of influences which initially propels the practitioner towards her eventually chosen career, although socialization into the career and subsequent experiences may alter the set of values, beliefs, and forces driving action in particular instances.

It is in the co-articulation of these beliefs and motivations which are directed towards the provision of societal services of some sort among persons of like goals (and requisite knowledge and skills), that the incipient external rules - the 'code' of conduct, practice or ethics - begin to be formulated. For example Viens (1989), who traced a history of the formulation of nursing's code of ethics, notes that in the early years (1921) of the code's development an advisory committee consisting of representatives of different nursing groups was formed. The

impetus was to develop some cohesiveness of purpose with regard to the care of patients. They wanted guidelines they could use as "a basis for professional conduct and in teaching ethics" (p. 46). In 1926 a tentative code was offered for comments and suggestions to nurses across the country. The code underwent many revisions over ensuing years. The latest revision is dated 1985, but there is further amendment process underway currently. A call for comments and input has been widely disseminated in nursing journals and in other venues. The 'code' is thus, in a manner of speaking, the tentative end result of an evolving profession's political process.

There continues to be, as one might expect, a tension between the internal and external aspects of the profession's rules of conduct. This is so for two main reasons: a) The internal aspects or driving force for the external code will never constitute more than part of an individual's value set leaving the remainder free to be at odds either with the external code, or with some beliefs of other members; in addition, internal aspects may well be subject to change with changing societal circumstances; b) The external aspect, symbolized by the code of ethics or conduct is constituted by vague rules, which do not always prove helpful guides for particular situations, and to which all members of the profession may not equally subscribe.

A nurse's values may conflict with the code, for

example if she believes that an alcoholic has 'caused his own illness'. She may be unable to bring herself to treat the person with the same respect she treats other patients. Another nurse may believe that in certain cases it is permissible to engage in assisting suicide, which is forbidden by the 'code'. A physician may believe that the physician-patient relationship trumps other concerns and regard it as someone else's duty to attend to societal needs in contravention of her 'code's admonishment to contribute "to an improved community".

Newton also calls the internal and external aspects in turn the "personal conscience" and the "Code". These "work together with difficulty under the most stable of conditions" because "it is of the essence of conscience to resist prior decision of cases by rules, which is precisely what the Code aims at doing" (1988, p. 50). Additionally, she notes that when societal changes are rapid there is a struggle to sustain an intelligible set of practice-guiding rules.

This understanding of the inception of a profession's code of ethics seems to me mostly correct, although it is not, I think, a full enough account. It is probable that professional socialization in part immunizes professionals from the effect of societal change, at least, until such time as they become directly affected by it; hence creating the paradoxical effect that a professional, far from having

Newton's "inclusive view" of what professional practice entails, may be blinkered.

Tunnel vision of this sort can interfere with the possibility of pro-activity (I am assuming, debatably, that professionals really are interested in promoting the welfare of society) on the part of professionals and, consequently, on the part of professions; a factor which no doubt is instrumental in the time lag between changing societal demands and the corresponding evolution of practice ethics. An example of this might be the failure of medicine in general to have an emphasis on patient education and health-promotion endeavors. Also the fee-for-service environment tended to encourage overtreatment -- a factor in the current crisis (Starr, 1982, 1992). Physicians have been slow to recognize this problem and address it.

Problems of Professional Socialization

Professional socialization and professional encounters, I believe, can also work in the opposite direction to make more homogeneous the values, beliefs, and even motivating drives of professionals with those of their colleagues. This holds especially with regard to professional issues, but there is inevitably an 'overflow' effect into a professional's interaction with her everyday life environment. For example, I once overheard a lawyer acquaintance bragging that he had saved a driver whom he

knew to have been intoxicated at the time of arrest, from punishment by challenging the breath analyzer test his client had taken. When I asked him if he had qualms about this he answered "no" he was merely fulfilling his professional role to the best of his ability[39]. On further questioning about the risks to others in society (including to the driver himself) of not holding the drunk driver responsible, he responded that those considerations were not part of his job.

One might have expected an expression of unease about this aspect were a question with similar intent posed to a member of the general public. For example, if we enquired of a parent, "is it permissible to cause potential or actual injury to another in the pursuit of the child's best interest?", in most cases the answer would conclude that it is only permissible in special high risk circumstances and then only after every precaution has been taken against injuring another. An example of this might be that a mother does not stop at a red light (although she slows down to check that the road is clear) to get her injured child to hospital[40]. Thus, consideration of surrounding circumstances is part of the role-specific advocacy action.

In another instance a nurse colleague of mine, while

---

[39]As was described in Chapter Two this is a truncated interpretation of the scope of moral obligation for legal advocates.

[40]This example was suggested by James L. Nelson.

working in a trauma unit, confessed that she had to force herself to try and feel something for bereaved friends since the fact of frequent deaths experienced in the unit had "anesthetized" her. Chambliss (1996), a sociologist who spent several years as an observer of nurses working within institutional settings, has described this phenomenon well in a chapter entitled The routinization of disaster (pp 12-41).

As it happens, both examples describe a numbing effect encouraged by aspects of professional life. In the first case this numbing affect was not acknowledged, in the second it was recognized. Recognition of the effects of professional activities upon an agent at least allows for account to be taken of such effects in any decision-making which occurs prior to action. For example, if we asked the lawyer how he would feel if his children were endangered on a future occasion by this same person driving under the influence, it might be possible to precipitate insight. However, it is generally agreed that people are good at rationalizing culpability away if they have a predisposition to this effect.

Earlier in the project[41] I discussed two moral issues

---

[41]In chapter two under the section *Criticisms of the Legal Advocate Role,* the problem of loss of 'authentic self' was discussed in relation to lawyers who do not consider the ramifications of a truncated moral view. A further issue discussed concerned the problem of not treating persons holistically while acting as their advocate.

of this type with regard to the role of lawyers as client advocates. Such matters will be explored further in the next section. It remains to be seen whether this fact of the dissemination of professional perspective into the everyday life of the practitioner, proves to have a stronger effect on professionals than it does on non-professionals. It is, however pertinent to the discussion of the moral status of professional roles because it is liable to blur the line between the role specific attitudes of professionals and the attitudes of professionals in their non-professional life.

To this point in the exploration of professional obligations I have made some preliminary distinctions. These distinctions have allowed occult factors to be brought to the surface. Groundwork of this sort was necessary to prepare the way for the ensuing and more particular task, which is to undertake a closer examination of the implications of codes of ethics for various disciplines. In attempting to understand what these disciplines suppose their obligations, particularly those of advocacy, to be with regard both to individuals in the society and to society as a whole, it is expected that at least one of the purposes of this study will be addressed. That is, some clarity will be gained concerning the issues of professional advocacy.

Later in this chapter I examine pertinent sections of the code of ethics of nursing and medicine as exemplars for

codes existent in health care professions. In particular, and since the main focus of this enterprise is on professional advocacy, I will scrutinize what these disciplines have to say regarding obligations to advocate. But first it is necessary to delve a little more into an examination of the nature of professional obligations.

THE PROBLEM OF PROFESSIONAL OBLIGATION

The Moral Status of Professionals

Underlying the larger issue of ambiguity regarding professional responsibility in contemporary society is the difficult question regarding to what extent professionals are subject to stronger or different claims made on them in virtue of their status qua professional than societal members would have on each other. Professional membership may entail what Windt (1989) calls "special ethical status". Critics of professions and professional activity have noted that some professional activity seems to place a given profession's members outside the realm of moral sanction to which general members of the public are susceptible. Examples of such conduct were given above and in chapter two in the discussion regarding "*criticisms of the legal advocate role*". But the criticisms of the ethical status of professionals are actually twofold.

On the one hand certain professionals, when acting in their professional capacity, seem to be held, or to hold

themselves, to what might be called a more lax moral standard than would be expected of societal members in their relationships with others in the society. For example, in special circumstances of client representation where the professional is in an adversarial position with regard to the client's opponent, she may act towards that opponent in ways that we would commonly consider morally culpable. See Chapter Two for examples of this.

The other type of deviation from an 'ordinary' moral standard concerns the idea that sometimes professionals are held to, or hold themselves to, a higher moral standard than other societal members. For example, the confidentiality norm is more strictly circumscribed for health care professionals than for most others in the non-health-care-related sector of society (exceptions to this rule would be the clergy and as I show later the lawyer-client relationship). Although Camenisch (1983) is careful to point out this standard is derived from a more general social rule that one should keep confidences when asked to do so, others might debate the origins of the principle.

Perhaps a stronger example is the increased risk to their own well being that health care professionals are expected to take in the course of their work. Health professionals are routinely exposed to risks beyond normal moral acceptability in caring for persons with infectious diseases. Consider the American Nurses Association (1994)

position statement on Risk Versus Responsibility in Providing Nursing Care. In this statement reference is made to the fact that "historically, nurses have given care to those in need, even at risk to their own health, life, or limb" (p. 2). There is, of course a limit to the risk the nurse is expected to take, but undoubtably in performing the service there is inherent risk greater than it is expected that lay persons would undertake. Open questions remain concerning what, if any, is the extent of special moral status for health care professionals is implied by the confidentiality or the risk exposure norms.

Windt (1989) has explored the phenomena of professional obligation. In his discussion on the ethical status of professionals acting in the professional role, he is mainly keen to look at the question of moral status for professions that have a "grinding, life-or-death sort of importance" such as "medicine or law" (p. 7). Windt's task is to uncover the moral imperatives of such well-studied professions with regard to society.

In Chapter Two the notion of role-differentiated moral behavior was discussed. Role-differentiation it was argued seems to call for a different ethical status for professionals in the course of their work than would hold for others under similar circumstances. The problem of granting what Windt terms "special ethical status" to some distinctive members of society, if taken at its most radical

interpretation, is iconoclastic. It is so because on the radical view professionals are allowed to treat some persons as if they had no moral standing or are not worthy of moral concern. For example, legal advocates who assume a 'functional role'[42] are implicitly claiming special ethical status in so far as they either ignore the impact of their actions on others or deliberately harm others in their quest to defend their client.

This is, as I argue presently, a different problem than the notion that there may be special rights and duties that are role-based. That is to say, if there is adequate justification for professionals to assume the radical version of a 'special ethical status' then the commonly accepted notion of some sort of universal ethical status applicable to all individuals as beings worthy of moral concern, is undermined.

Undermining this particular conceptualization of "universality" is morally destabilizing. It essentially annihilates the ideal of persons as having equal rights to certain goods or to certain treatment. Theoretically at least, the radical view of 'special ethical status' permits the unequal treatment of persons as defended above. A reminder is perhaps needed that the notion of 'universality'

---

[42]The notion of functional role is discussed later, but the essential idea is that the lawyer gets the task done without undue concern for the impact her actions will have on either the client or involved others.

is a requirement of logical consistency regarding moral behavior not support for absolute principles of morality. In this sense, it need not rule out special rights and duties for groups of people like professionals[43]. The consequence of granting 'special ethical status' to professionals seems to mean that obligations incurred during pursuit of professional activities may be radically different than those of citizens in general. However for the reasons given above, it is not clear that even with stringent justification for ethically relevant differences in moral status between civilians and professionals we can maintain coherency in a society's values and, consequently its justice arrangements, if we affirm the 'radical' view of "special ethical status" for professionals as valid.

Special Moral Requirements of Professional Role

It is not Windt's task however to propose we accept the most radical view of 'special ethical status'. Indeed it is to this notion of special ethical status for professional roles, proposed by Goldman (1980) as "strongly differentiated" (p.3), that Camenisch (1983, p.57) most strongly objects. Special status is not crucial to the enterprise of demonstrating that professionals may on specified occasions prove subject to different moral expectations than members of the general public. Windt

[43]This point was suggested to me by Glenn Graber.

thinks that this can be accounted for in the manner that different obligations are expected of other members of society according to the role assumed and the, at least implicit, purpose of the role.

His example is that of parents with regard to their children. The society tends to expect parents to exhibit a certain partiality towards their children perhaps especially when a child is involved in a problematic situation. For just such reasons, they by virtue of their parental relationship are charged with acting on their child's behalf. The child is assumed not to possess the adequate knowledge or cognitive development to procure for herself, or to ensure procurement for self, those things necessary to either a fair resolution of the problem, or continued well-being. However, on another similar occasion we might expect impartiality in the person's stance if that person does not have a child involved in the problem.

Goldman (1980) too has addressed this issue of the differentiated demands of special roles. Family serves as an illustrative model in that, "family members are expected to weigh each other's interests more heavily than those of strangers, to provide for each others needs as they would not for strangers" (p.4). He cites two reasons for this, one reason is that there are 'instrumental' advantages of a social structure where the needs of intimates are elevated in importance over the needs of others. But there is also an

internal advantage of the relationship that defines such special obligations, that is, intimate relationships facilitate human fulfillment and flourishing. Of course, this may be seen as a psychological fact which does not necessarily culminate in a moral mandate that such intimate relationships ought to entail special obligations.

I do not intend to offer a defense of the 'fact/value' distinction here. It is sufficient to say that having such a model, as the parent/child relationship, outside of the professional setting allows a beginning point with which to look at elevated or decreased moral obligations that differ in degree from more general societal moral norms. For Goldman (1980), then as for Windt, it seems that

> the complete justification for strong role differentiation requires that the institution in question serve a vital moral function in society. The elevation of the norm central to the discipline must be necessary to the fulfillment of that function. (p. 7)

The justification of this less radical interpretation of a special ethical status for professionals comes from the special intent of the profession with regard to the problem at hand.

Thus it can be seen that, "more moderate accounts of professional role ethics" (Windt, 1989, p. 21) are available. Moderate accounts have a feature they share with each other; that is, they

> all focus on derivative-level differences between the ethical status of various professionals and the ethical status of non-professionals. The crucial problem for such moderate accounts is to determine which essential features of a profession justify deriving role-special values and principles from the common fundamental values and principles shared with other professions and with non-professionals. (Windt, 1989, p. 21)

These fundamental values and principles are whatever is apparent explicitly or implicitly in the culture. Agreement with this idea that any differences in moral obligations are indeed derived from the philosophy, goals, and nature of the discipline may be found in a number of other works. The fundamental goal of medicine is generally described as healing or restoring health[44], while nursing has espoused its goal as promotion of health. These may seem synonymous goals[45] but there are differences in perspective. It is also true to say that for any given patient 'health' may require

---

[44]I am not as convinced as some that physicians in general see themselves as health promoters. Public health physicians may be actively engaged in health promotion but many other specialist physicians and surgeons could not currently be viewed as having a disease preventative outlook.

[45]I believe this seeming similarity of ultimate goals for the two professions has led to the uninformed critic's assumption that nursing is somehow a sub-section of medicine. I have discussed such misconceptions in Chapter One. The difference between these health care professions is perspective or approach. The difference in perspective stems from the underlying philosophies of these (and other health-related disciplines) with regard to human flourishing.

the services of a variety of health professionals. Legal advocacy has as its foundational value the defense of individual rights. Each of these goals is prevalent in our society in general.

Goldman (1980), has noted the importance of first settling the question of "special norms" for professions; this must occur before the intricacy of "concrete moral problems faced in practice" (p. 2) can be appreciated. It is the foundational goals of each discipline which mandate whether altered moral weighting is required on the part of its practitioners in order to further these goals. This means, for example, that within the health care professions 'health' is elevated to "the status of (an) overriding consideration" in circumstances where it "might not appear overriding from the viewpoint of normal moral perceptions (Goldman, 1980, p. 3).

Camenisch (1983) calls this aspect the professional's "atypical commitment". This commitment is attached to "a societally defined role, a set of rights and duties, which the professional takes on when, in the context of this society one presents oneself as a professional" (P. 34). Essentially, then, the professional has increased obligations with regard to those who are served by her practice, the intent of which is to achieve the goals of the particular profession.

Thus it can be seen that further considerations

regarding professional activity involve determining: Who exactly are the professional's constituents? Are they those who have a direct (if implicit) contract with her or is the constituency broader than this? If the professional is indeed distinguished by her breadth of vision for the services she provides, as Newton suggests, then it seems the health care professional must include not only concern for her present clients but also for the health of future clients. The problem of addressing health needs for future but as yet unknown clients broadens the professional's scope of concern to a societal level.

Value Coherency and the Survival of the Professions

It may be expected, then, that there exists a close relationship between the fundamental values of a society and what professionals perceive to be their obligations to societal members or to society as a whole. Professionals in general are members of the society in which they practice, and in most cases reside, there are exceptions to this as I noted earlier. Thus they are (also in general) subject to societal influences both from interactions with their client population and as a result of the portion of their life spent outside of the professional role. It may be further anticipated that when there is dissonance in a society's value set there will be dissonance and uncertainty regarding the nature and extent of a professional's obligations. It

might be argued that it is the nature of moral obligations to be obscure in many circumstances because the contemporary environment is extremely complex.

There is a whole body of literature to support this contention. However, I maintain that there are certain indicators which highlight *critical incoherency* somewhere within either a society's value system or a society's supposed value system. It is my thesis that there exists a problem currently (this is not to exclude the fact of prior health care delivery problems) such that health care professions are experiencing an inability to accomplish what they profess as their mission, and what society in turn apparently sanctions as an expectation of the profession. Further, such difficulties should serve as alarms for our society for obvious reasons. I examine this assertion in more detail later[46].

However, Daniels, Light and Caplan (1996), in discussing the failure of 1994 health care reform efforts, have ascribed such seeming inconsistencies in US societal values to the political strength of powerful special interest groups whose protestations skew the values picture of the country. They caution against prematurely subscribing to the notion that as a country we are no longer interested in equality of opportunity, including the opportunity for fair health care provisions. They do so for the reason that

---

[46]See Chapter Four and Chapter Five

the most loudly or persistently expressed views do not necessarily cohere with the values of the disenfranchised or of the majority of American people.

It is perhaps necessary to briefly recap the issue of societal values as mentioned in Chapter Two. In that chapter it was pointed out that it is not required that we hold out for the discovery of absolute moral truths in order to examine a system's values for coherency. Several criteria were proposed in that chapter under Assessing a societal value system which when not met might point to coherency problems. It is important to note that I am not asserting here that we can decide absolutely whether a given society has a completely coherent value system, I do, however want to claim that we can critique an aspect of a society's framework in this regard and to show in what ways it falls short of coherency. In doing so the goal is to engage more citizens in the debate and to lay bare some of the occult interests so these may be critiqued allowing the involved parties to be held accountable for their activities.

For example, in health care a pivotal point to be considered in proposing that A has a right to the opportunity for certain level of health is the degree to which the claim can be met. It is not my purpose here to get into the sticky subject of the correlativity of rights and duties in general but to look in more detail what claims may be validly made of health care professionals with regard to

professional advocacy. What I want to say here is that if it proves not feasible to meet a claim for health care, and yet it is apparent that society, in the main, agrees that a certain level of health care is a right of citizens then it may be noted there is a flaw in the system. The flaw concerns the principle that 'ought implies can'[47]. This means that obligations only obtain (when they obtain) where there is a possibility of fulfillment of these.

This is not to say, however, that there are no professional obligations to expose existing problems concerning the realization of society's values with regard to professional goals. This barrier to realization of values must be exposed somehow if any redress is possible. For example, if the US's emphasis on equality of opportunity continues to be an important societal value but there is no great effort made toward realizing this ideal, the reason for the lack of effort should be exposed by those capable of so doing. Such exposure is important for many reasons but mainly because everyone is susceptible to a change in circumstance which could result in decreased opportunity. This is especially true with regard to opportunities for health care. Health policy and ethics analyst Emily Friedman (1996), in discussing problems surrounding the provision of health care, has convincingly illuminated the universal vulnerabilities of humanity. She pointed out that,

---

[47]Suggested by Betsy Postow

> Health care, managed or not, must be a place of safety, a sanctuary for all of us, the least and the great alike. Because any of us, at any time, could slip, or misjudge, or lose too much, or live too long, or just become overwhelmed, and could so easily join those who stare over the edge of the precipice. (p. 21)

Daniels et al (1996), illustrate this point further with their comment that fair provision of health care is important because "disease or dysfunction restrict(s) access to life's opportunities" (p. 21), and this equality of opportunity is a pivotal value in American society. Thus obstacles to the provision of health care hinder the rights of certain individuals in society with regard to equal opportunity. Impediments to health care provision may result from a misunderstanding about what it takes to operationalize these generally agreed upon values. Alternatively they may result from the difficulties involved in exposing concerted dissimulation efforts by powerful special interest groups. At any rate, it makes no sense to propose certain professional obligations where circumstances militate against fulfillment of such obligations or of large portions of these. I shall claim, however, that professional obligations do exist to the extent that these are possible to fulfil.

It will be demonstrated that as long as professions (at least corresponding to the traditional view of these) can be

said to exist, they have a collective responsibility to be advocates for society where this proves necessary for furtherance of the goal of the profession. This is so because, as earlier noted, they have the knowledge and skills to: 1) Identify barriers to realization of societal values with regard to their particular goal or purpose; 2) awaken the public to risks inherent in not reinforcing the value of the profession's purpose; that is, the furthering of a particular societal good; and 3) a special responsibility, delegated to them by society, to propose and illustrate the benefits of alternative methods of realizing societal values with regard to the good in question.

Suffice it to say here that because of the complexity of contemporary life, which includes the presence of certain barriers to provision of a service that accords with societal values, it is easy to miss this critical point, that for a variety of reasons, many of the demands made of professionals may not be able to be met because the professional is not free to meet them[48]. This proves an additional complication for health professionals who already are grappling with issues stemming from tension between realizing obligations to individuals and obligations to society.

---

[48]I gave an example of this earlier in the chapter. The example given concerned the fact that a managed care company was constraining the physician's choice of medicine for a given patient.

Two important questions have emerged from the above discussion. Firstly we must ask: To what extent does the responsibility for maintaining coherency in a society's value system, with regard to the specific goal of the profession fall to a profession and its membership?; secondly, and perhaps more subtly, there is the need to question the very viability of professions in a contemporary environment where economic issues seem able to take precedence over moral ones and where business interests have the power to direct professional practitioners.

It remains an open question, then, whether contemporary professions are viable entities as currently conceptualized. If notions of the purpose of professions prove anachronistic, a more realistic contemporary conception of the mission and capabilities of what have heretofore been termed professions may be required. At the very least it is important to ensure society is apprised of any circumstantial inability of professions to further the goals of their particular service. Ironically, as noted, such public awareness may be elusive in view of both the obscure and specialized nature of professional knowledge and the manipulations of special interest groups.

I will argue in more detail in Chapter Four regarding the point made above that social as well as individual advocacy is a professional role-linked moral imperative under certain conditions. This obligation to promote the

goals of the profession at both the individual and the societal level is acknowledged in both the AMA and in the ANA code of professional ethics but to differing degrees. Thus, the point that societal and individual advocacy are role-based expectations of certain professionals is defensible. However, in the current environment of health care provision at least certain aspects of advocacy do not seem feasible. That is, it is debatable to what extent advocacy of an individual is possible when a third party is directing what services may be provided[49]. Minimally these aspects of advocacy are not feasible to the extent society demands them of the members of a profession. As I discuss further in Chapter Four, members of the public expect that the health care provider acts in a given individual's best interests[50]; however, this may not be possible if certain options that (are generally, or have traditionally been available) would truly be in the individual's best interest are not part of a person's managed care company plan.

This next section is focused specifically on an examination of professional obligations regarding advocacy. Windt's notion of 'derivative role-special' values related

---

[49]Advocacy on the level of appealing problematic decisions is, of course, still possible; but the main point I am making is that professionals have an obligation to challenge systemic forces which give rise to advocacy needs.

[50]To the extent this is possible given existing conditions.

to health (however this may be defined by the given profession) will be used as a tool to analyze the force of obligations stemming from the profession's practice arena. Specifically, as noted earlier this subject will be investigated from the vantage point of the codes of ethics of medicine and nursing, although it is assumed that many implications of the analysis will be applicable to other health professions and, perhaps, some non-health related professions as well. Additionally, comparisons will be made where applicable to the obligations supposedly incurred as a result of the legal advocate role. Finally, it is necessary to consider the ramifications of and constraints on advocacy obligations both for the professional and for society.

Codes of ethics: The Obligation to Advocate

It is pertinent at this stage to inquire where professional advocacy fits in the set of a given profession's obligations. A review of the codes of ethics of various disciplines shows advocacy as one perceived obligation among others. However, professional obligations, as might be expected, bear a relationship to each other. They do so for several reasons which will become more apparent as this analysis progresses. A pressing unifier, though, is the notion that obligations are acquired as a result of membership of the profession. Hence, they are

directed at the furtherance of the main or over-arching goal of the particular profession. Membership in a given profession is entered into more or less voluntarily. In entering the profession one is presumed to willingly affirm the commitment to furthering the main goal or purpose of the profession.

In Chapter Two a preliminary or working definition of professional advocacy was offered. There it was stated that professional advocacy may be viewed as certain actions taken out of a perceived obligation to another or to others and occurs either within or as a result of the professional-client relationship. Additionally, it can be seen from the preceding discussion that it may be required to further the goals of the profession with regard to society in general. Chapter Two's definition was as follows: The concept 'advocacy' when used in association with professions and professional roles carries the implication that there exists an unmet, but potentially correctable, need or deficit on the part of another. The deficit may involve a projected or future inadequacy of some sort and/or the inability to gain a particular benefit that is determined to be a person's right under the justice system. Therefore, advocacy includes preventive types of action such as education and political-activism. The deficit, then may be an individual or group's lack of certain specialized knowledge or of the skills and technology to achieve a desired good. The professional in

virtue of her role has the capacity to provide, directly or indirectly, the expertise to address the deficit in some way.

For professional advocacy to be viewed as what Camenisch has termed an 'atypical moral commitment' of the profession, it seems that AAA (or advocacy that is not primarily self-centered) must be a value common in the larger society. For the earlier argument regarding professional obligations concluded that professionals do not have a different moral status than non-professionals; rather, any duties expected of the professional are essentially duties which may be expected of other non-professional members of society in certain circumstances, or under particular conditions. It is the profession's expressed devotion to the promotion of a specific societal good together with societal sanction of this aim which fortifies the professional's obligation in this regard. The augmentation occurs because the professional is assumed to have the knowledge and skills which best fit her for realization of the duty **and** as a member of the profession has undertaken to be especially diligent in promoting this particular good.

Examples of AAA do exist in the community at large and also seem to be a societal expectation. Once again we may draw on the earlier given model of parent and child. It seems to be expected of parents that they go out of their

way to procure needed items or services for their child when necessary. This is a role specific expectation.

As mentioned earlier, the strength of moral commitment to any given venture varies even among non-professionals. It is circumstances, capabilities and relationships between individuals which dictates the strength of obligation the agent perceives as accruing to her. What is clearer is that the assumption of a professional role places stronger obligations on the agent with regard to the goals of the profession than would hold for lay persons. In this way a given obligation functions as a dependent variable which undergoes fortification, or is, as Camenisch (1983) terms it, is 'heightened' where professional duties demand this. Though the fact of the profession's expressed intention to further a societal good is the main fortification factor for members, the degree of fortification may be susceptible to other factors as we shall see.

A consequence of assenting to this viewpoint is that professional advocacy may be seen as possessing strong links to AAA. The strength of an individual's predisposition to advocate may well involve the degree to which elements of altruism exist or perhaps have been nurtured within the

character of the individual professional[51]. The primary thrust of the obligation, however, is the furtherance of the main goal or purpose of the profession. Professional advocacy must be seen as a broader concept than that explored in Chapter Two under legal advocacy. For whereas legal advocacy (which may realistically be considered the progenitor of advocacy as an obligation of health care professionals) is the representation of a single client or perhaps a group of clients against an adversary and is an obligation of legal professionals engaging in client representation, professional advocacy for health care professionals is a much broader concept.

The intent of advocacy actions for health care professionals must include the notion that sometimes advocacy on behalf of individuals, as a result of an implied contract, will not be sufficient to further the main goal of the profession with regards to society. It will therefore be part of the professional's obligation to undertake advocacy actions aimed at furthering the dominant goal of the profession. What this illustrates, as I have said, is a

---

[51]Earlier in this chapter is was pointed out that the driving forces pushing individuals toward a certain profession include the internal value of service to others. Thus altruistic characteristics are linked to three facets of professional life: 1) A 'structural' component of personality moving a person towards a particular profession; 2) A tenet of the profession's code of conduct formulated as a result of the discourse among the professionals; 3) A combination of 1 & 2 and the context of the particular problem requiring professional advocacy.

point of departure from the original notion of advocacy as a role of the legal profession.

Advocacy Notions Derived from the Codes of Medicine and Nursing

Utilizing the definition of professional advocacy set out above it is possible to extract from the codes of conduct of both medicine and nursing what these professions accept with regard to their obligation to advocate. It will be readily seen that there are assertions not just of responsibility to individuals but also to society. The main questions then become: Given that we accept as valid the notion that professionals possess 'role linked' obligations to advocate dependent on client or societal need and (to a certain extent) on the strength of professional motivation, how is the professional to reconcile competing advocacy obligations? Another problem to be addressed concerns the boundaries of the professional's, or profession's, obligation to the individual or society when one of the following occurs: There are institutional barriers to advocacy, or societal barriers to health care are instrumental in causing or exacerbating a need or result in an unmet need.

Rules of Conduct for Medicine

Following the order in which these disciplines were

discussed in chapter one, I will first lay out some pertinent parts of the American Medical Association's (AMA) Principles of Medical Ethics (1980) which, interestingly in view of contemporary developments, are the most recent revisions.

Among the statements in the 'Preamble' is the following: "As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self." Plank III states, "A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient." Plank V involves an assertion of the physician's responsibility with regard to continuing education, dissemination of pertinent information to the peers and the society, and provides for collaborative efforts with other professionals. Finally, in plank VII, which is perhaps the statement with the broadest mandate, physicians are exhorted to "recognize a responsibility to participate in activities contributing to an improved community." There is no tenet which provides guidance regarding under what circumstances it may be permissible to favor the needs of society over the needs of the individual or vice versa.

Curiously, the aspects of this code that are salient to the current project do not seem to hold the special fiduciary nature of the physician-patient relationship as a

stronger duty than that owed by the professional to society in general. Indeed what does appear to be validated is Jecker's (1990) proposal[52] that maximally restricted advocacy (of the individual) is the correct view of physician advocacy because only this perspective assures social responsibility on the part of the medical profession. Jecker's conclusion is that "medical professionals are ultimately the ones who must rise to the occasion and implement restrictive social practices" (p.138).

I shall show that while this view goes part way to addressing the complexity of individual versus societal advocacy issues it is lacking some vital considerations. At the hub of these considerations is a problem reviewed in Chapter One; this discussion outlined the argument that giving sole attention to an individual's needs can be problematic to the society, but giving priority attention to societal needs fails to respect the humanity of individuals, and societies are after all societies of socially situated individuals.

Moreover, a more important task for physicians may be to expose structural and economic foundations of a health care delivery system which has built-in restrictive and exclusionary practices. What I am proposing here is that the medical profession may be morally required to challenge a

---

[52]See Chapter One for the original discussion of Jecker's argument.

health care delivery system which is unjust because they are among those who are best situated to tackle such issues. Societally based injustices may result in the necessity to advocate on an individual level for those needy but fortunate enough to at least have access to care. But advocacy may also be required at a higher level **both** for those excluded from care for various reasons, and for those whose individual advocacy needs have resulted from an unjust system. The following provides an example of one whose advocacy needs have resulted from injustices within the health care system: As a result of cost-cutting measures by the hospital and insurance company Ms A. an eighty-year-old woman is sent home several days earlier than is recommended by her health care provider. She has an inadequate home support system for her care. Although she has visiting nurse services for her wound care, she is unable to tolerate standing for any length of time, therefore, is not receiving adequate nutrition. In Chapter Four I discuss such problems in more detail, however, the important point is that addressing the problematic practices of institutions requires a higher level of advocacy.

This task too proves susceptible to the tensions described above between the professional's attention to individual needs as required by society and the larger societal problems. It will become clear later that Nagel's (1991) examination of this type of problem in his book

Equality and Partiality sheds some light on the difficulties inherent in reconciling the components of this apparent paradox.

Nagel's discussion is focused on the moral problems of individuals in general as they are able to view themselves as both solitary self-interested units with projects and goals, and individual selves among many other such selves - the interested constituents of society. His intent is to analyze the issue described above which he terms the "central problem of political theory" (Nagel, 1991, p.3). The problem is summarized by Nagel in the following manner:

> When we try to discover reasonable moral standards for the conduct of individuals and then try to integrate them with fair standards for the assessment of social and political institutions, there seems no satisfactory way of fitting the two together. They respond to opposing pressures which cause them to break apart. (1991, p. 5)

The pressure on the one hand stems from the individual's interest in his own welfare, and on the other comes from abstracting from this to the notion that other individuals have an equal interest in their own welfare. If our lives matter to us then we are faced with the acknowledgement that other's lives matter to them and matter more or less as strongly to them as ours do to us. There may be exceptions to this as in the case of depression where a person may have

lost interest in her own projects and goals. However, the importance for professionals in this partial versus impartial stance involves the notion of integrity. Strain results from the fact that "a human being does not occupy only his own point of view", consequently, "each of us is susceptible to the claims of others through private and public morality" (Nagel, 1991, p.4). We can't engage in both the impersonal and personal stances at the same time, but some reconciliation is necessary for both the harmony of the individual and the relative harmony of the society. If we extrapolate from this notion of tension experienced within an individual between personal (partial) demands and social (impartial) considerations, to the pull on the health care professional between the needs of the individual patient (partial) and the needs of the group, community, or society (impartial) one can appreciate some of the difficulties health professionals face[53].

I will examine Nagel's paradox later, for it has relevance to the moral outlook of health care professionals. Consider the following illustration of Nagel's thesis regarding the irreconcilable nature of these opposing

---

[53]Nagel's purpose is to point out that an individual is able to take both her own personal (partial, subjective) standpoint and the impartial standpoint. The extrapolation from this for health care professionals is that an individual who is advocating takes, or at least acts as if she takes, someone else's personal (partial) standpoint, as well as the impartial standpoint. This clarification was suggested by Betsy Postow.

tensions: If we compare the principles found in the Code of Professional Ethics (AMA, 1980) with those contained the American College of Physicians Ethics Manual (1992) we find a disparity in emphasis regarding physician obligation. In the former priority seems to be placed on the interests of society over that of the individual, and although individual interests are also mentioned there is no guidance regarding under which circumstances one may receive priority over the other. In the latter there is a clear mandate to promote "the patient's welfare and best interests" these are "the physician's main concern" (p. 3). In this document stronger weighting does seem to be given to the needs of the particular individual who must be viewed as "unique" and worthy of "respect" (p. 3) and, seemingly, weighted more heavily in the physician's obligations, than are broader societal needs.

Certainly, there is some guidance in the code with regard to such things as the permissibility of breaking confidentiality; that is patient "confidences" shall be kept "within the constraints of the law" (Principles of Medical Ethics, 1980, IV). However, there is not much directive guidance for the physician on those occasions when there is a tension between the needs of the individual and the interests of the society.

Nursing's Code of Conduct

Corresponding concerns for nurses may be found by studying the American Nurses Association Code for Nurses With Interpretive Statements (1985). The 'Preamble' avows among other things that "when individuals become nurses, they make a moral commitment to uphold the values and special moral obligations expressed in their code." In plank one the nurse is exhorted to provide service to individuals which while honoring their uniqueness does so without prejudice regarding personal attributes or the disease type. In the interpretive statement to plank three it is asserted that the nurse's "primary commitment is to the health, welfare, and safety of the client. As an advocate for the client, the nurse must be alert to and take appropriate action regarding any instances of incompetent, unethical, or illegal practice" (ANA, 1985, p. 6). The fourth guideline affirms both a nurse's individual accountability and the profession's accountability to particular persons and to society. The interpretive statement for this plank includes the assertion that accountability is founded in the premise that individuals are 'self-determining' and have individual value. Plank eleven directs the nurse to unite with allied health professions as well as the public in order to answer the health needs of the society. The ninth tenet counsels the nurse to ensure that when nursing takes place in

institutional settings she should work towards guaranteeing that her practice will be in "accordance with the standards of nursing practice" (p. 14).

Thus it may be seen that nursing, like medicine, is susceptible to the strains of opposing interests. The origins of these strains are manifold. Some may emanate from the agent herself and some are environmental or political in nature. Nurses have had a continuous struggle with obstacles to the delivery of good care as defined by the profession. Some of these problems were previously discussed in Chapter One. The nature of these obstacles has been historically more problematic and of wider scope than the obstacles to service experienced by physicians. However, the current health care climate has precipitated opportunities for health care professions to re-examine the realities of providing services in a health care delivery system which is in crisis.

Crisis in health care delivery means that substantial numbers of the population are not receiving the care they need. The corollary to this is that the society has ceased any pretense at movement towards ensuring equality of opportunity in obtaining health care services. It is becoming increasingly obvious to those interested in fair health care provision that it will require the effort of the public in addition to that of health care professionals if any redress in the situation is to be possible.

Additionally, the skills of moral and political philosophers are required for clarifying the underlying issues.

CHAPTER FOUR

PROFESSIONAL ADVOCACY: TENSION BETWEEN MANDATES AND CONSTRAINTS

INTRODUCTION

Societal and Professional Expectations

The project as it has developed so far has led to the preliminary determination that Professional Advocacy, if an obligation, is so because it is both a societal and professional expectation of the role assumed by an individual as a member of a particular profession[54]. It is an obligation accrued upon undertaking a professional role. Moreover, it is possible to gain an understanding of what professional expectations are with regard to role-specific moral conduct by an examination of the code of ethics for the given profession. This is so because, as I have argued, such codes are formulated as a result of the profession's political process. Codal tenets address the manner in which the main goal of the profession is to be furthered.

What remains to be exposed, then, is both the extent of the obligation a professional is committed to as a result of professional membership, and the function of 'professional

---

[54]See Chapter One for conceptions of advocacy as advanced by commentators on the disciplines of nursing and medicine.

advocacy' related to these obligations[55]. Further, it remains to be discovered what other obligations may be contingent upon encountering obstacles to the fulfillment of professional responsibilities. I shall propose that professional advocacy is a complex role-responsibility. Because this is so a more complete understanding of professional advocacy facilitates furtherance of the goals of the profession. For this reason I shall undertake a additional parsing of the concept as it is used or implied in the professional context, especially in regard to the health care professional.

LEGAL ADVOCACY AS PROFESSIONAL ACTION

Advocacy as Agency:Lawyers as Representatives

In Chapter Two it was noted that for the legal profession, members who act as client representatives in the adversary system are, at least ideally, client advocates in the fullest sense. That is, advocacy should be considered as the overarching obligation during a given professional-client encounter. Cohen (1988) has objected to the conceptualization of the adversary role as being a 'functional' one. He notes that certain lawyers seem to subscribe to this view of the role. This perspective interprets the adversary role to involve no more than a

---

[55]Later in this chapter I also discuss the relationship of professional advocacy to the problem of partialist versus impartialist considerations.

'functional'[56] defense of an individuals right's, the activities of which are directed at winning the case at all costs without regard to moral side issues.

Cohen (1988) regards this view of the moral responsibilities (or relative absence thereof) of the law professional as legal advocate to be in error. His and other such criticisms of the adversary role were discussed in Chapter Two. However, I, like Cohen, shall maintain that the 'functional' construal of the role is not 'professional advocacy'. From the 'functional' perspective a lawyer is not fulfilling her duties to serve the best interests of her client; indeed the client's best interests may prove subservient to the goal of triumph over the adversary or to expediency in settling the case. For on this view, as Cohen (1988) has pointed out, what makes a lawyer 'good' is the ability to win cases by any means necessary.

Although an individual (or group) may seek out legal expertise in order to gain assistance in defending a particular position, our expectation is that the legal representative will have the client's best interests in mind in undertaking the case. It is hoped that the lawyer holds the client's best interest foremost over either the challenge of winning, or of completing the task most expediently. Paying attention to an individual's best

---

[56]This issue was discussed in Chapter Two under the section *Lawyers as Advocates*.

interests necessitates discovering enough about the individual to make this feasible. One can't know what is in a person's best interests without knowing something about the person[57].

Take, for example, the case of a woman who wishes to complete divorce proceedings because of irreconcilable differences between herself and her partner. Suppose, it was hoped by the individual to complete the formalities in a non-adversarial and informal fashion, but the erstwhile partner for, perhaps, understandable psychological reasons is delaying signing the necessary documents. She seeks legal counsel in order to expedite resolution but wishes to obtain it in the least painful manner possible for both parties.

Lawyer as Functionary

A lawyer who is playing the 'functional' role we might expect to take the easiest, although perhaps not the least expensive, nor the least traumatic, route to resolution. Her strategy could involve whatever she has found to be the most expedient in getting results; however, it is possible that this path leads to further alienation of the parties. The lawyer assumes that because in the past she has had results

---

[57]Even then it is not possible to know what will in reality serve the person's best interests because the future is unknowable. However, it is surely closer to the mark to make an informed judgement regarding which action is the best one for **this** client in **this** situation instead of assuming this person's best interests will correspond to one's own.

from this method, she knows better than the client what will work with the client's spouse. However, she has troubled herself neither to learn about the client nor anything about the spouse. Any subsequent alienation caused by the lawyer's indifference to contextual information is liable to exacerbate ill-will between the two. The potential ramifications of actions taken from the 'functional role' perspective include negative effects on the parties and any children they have in common.

Meanwhile a lawyer who construes her obligations more broadly and respects the client's individuality will consider the situation from the client's perspective and suggest the best path based on both the context and cogent knowledge about the client as person. So a narrow interpretation of the legal advocate role as purely 'functional' leads to the conclusion that this type of lawyer cannot be considered a professional as it has been defined by scholars such as Flexner (1915), Carr-Saunders and Wilson (1933), Kepler (1981), and Newton (1988). She cannot be considered a professional on any but the loosest use of the term for the pressing reason that society expects more from members of this (or any) profession. Functional roles seem more characteristic of what Newton and others have called 'craftsmen', although they may be too narrow an interpretation of a craftsman's role also. Many artisans take pride in tailoring their products to accord with the

desires of individuals.

Accountability and the Lawyer

Newton (1988), it will be remembered, emphasized the importance of accountability. By accountability she means that an integral part of being a professional concerns the fact that the professional "comprehends both the person ultimately served and the knowledge essential to the service" (p.49)[58]. It is through this lens that an understanding of the professional's obligation to the client is captured[59].

The concern of the individual lawyer, then, while acting as client representative, is to defend the rights of that individual (or perhaps that group) from the perspective of the said individual (or group). The individual lawyer is 'accountable' to her client in this manner. That is, she is required to understand both what is demanded in order to address the client's need and how her knowledge of the law can best help **this** client. Moreover, her membership in the legal profession is the foundation of her commitment to further the aims or overarching goal of her profession with

---

[58]I presented an explication of Newton's meaning in regard to this quote in Chapter Three.

[59] See Chapter Three under the sections Professional Accountability and Special Moral Requirements of the Professional Role for further discussion on this point. The preceding discussion regarding the inadequacy of a 'functional' construal of professional role is also cogent to the notion of accountability.

regard to this client. A review of the 'Model Rules of Professional Conduct' would uncover the moral framework of the practice for which she is accountable.

It may be noted that were this the only type of work a legal professional could undertake, then the legal system would serve a very different purpose than it does now. Legal advocacy is best seen as only one section of the justice system in general. Although it may come to the attention of a legal advocate that a particular law leads to injustices, attempts to alter the defective law must generally be made at a different level and outside of the professional-client relationship. It may be objected that there are occasions when a lawyer wishes to perhaps test a 'theory' or challenge a law and files a case with that purpose in mind. In such instances the lawyer cannot truly be said to be assuming the legal professional advocate role as this has been defined, for her main goal, in this instance is not protection of her client's rights.

Although there may be instances when a **client's** purpose is to test an unjust law, the lawyer's objective in such instances is not to prove the law unjust per se (though this may be a bonus side effect) but rather is to defend the client in her **claim** that the law is unjust. There may be exceptions to this, for example, if the lawyer wants to 'test' the law with a particular client's case. My point, however, is more subtle; it is that the lawyer while acting

as client advocate has as her sole purpose the furtherance of the client's interests. Therefore, the testing of unjust laws does not necessarily involve advocacy unless this also defends a client's claim.

It thus emerges as an assumption that the compromised individual seeking the services of a legal advocate does so because she is not capable due to lack of skill, or knowledge, or time, or a combination of these, to defend her own rights with regard to the law. Lawyers exist to fill this vulnerability gap for individuals in exchange for the ability to make a living and for realization of a service commitment no matter what the original motivator for this might be. It is mainly at the level of accepting or declining clients that a lawyer makes a choice regarding the moral acceptability of the claim being made by the defendant[60], although there are also sanctions against allowing a client to testify in a way that the lawyer knows to be false. As seen in Chapter Two, however, moral considerations may emerge at any point during the advocacy engagement and provide tensions, for the morally sensitive lawyer, between role expectations and personal authenticity.

Action as Advocacy

How these principled considerations get resolved

---

[60]This privilege of choosing whom to serve is crucial to the following discussion regarding social advocacy. But I will delay analysis of this problem until later.

depends upon a variety of factors. That is, they are dependent to a certain extent upon the character, moral development and level of experience of the advocate, in addition to contextual influences. It may realistically be asserted, at least prima facie, that any action taken by the advocate in the interests of furthering the client's cause is an advocacy action. There may, of course, be contaminating factors. The advocate may genuinely think she is acting in the client's best interests when in reality she is imposing her view of what is desired, or desirable, upon the situation[61].

For example, in the earlier-discussed divorce case the lawyer may think getting a better financial deal for her client is in the client's best interest because this is what she would want in the same circumstances. However, it is possible that the divorce petitioner would rather have less money in order to have a less acrimonious divorce. In human relations this substitution of one's own ideals for those of another is an ubiquitous problem. Even the most self-reflective person cannot remove herself totally from her own subjective stance. However, awareness of such contaminants as a possible factors in decision-making facilitates more movement towards the ideal, than does lack of self-

---

[61]This is different from the functional role problem in that the effort made by the advocate in this instance is supposed by the advocate to be in her client's best interest. Whereas the functional advocate's efforts are aimed at winning the case.

reflection regarding both professional and personal values.

Legal Advocacy and Paternalism

The preceding discussion draws out a difficulty presented to the client of the legal advocate. This difficulty concerns the wherewithal to guard against undesired paternalism. Paternalism associated with the lawyer-client interaction was investigated more fully in Chapter Two and will be discussed further as a possible problem of the health care professional-client relationship. 'Paternalism' is a complex notion. Arguments for the permissibility of paternalism have as a basis the belief that the individual's own moral or physical best interest will be better served by the intervention of another or others than it would be by the individual's own actions. As Sartorius (1983) points out, J. S. Mill made a significant contribution to our current understanding regarding what sorts of reasons for actions could count as valid justification for paternalism.

Some commentators would claim that 'paternalism' is warranted in certain cases. Their arguments, if adapted to the case of the legal advocacy relationship would be required to hinge on the notion that the advocate in virtue of her specialized knowledge base may be correct in her assumption that she knows which action will provide the best results for her client even in the face of a contrary belief

by the client. If we grant this assumption[62], it must be because there is a belief that the complicated nature of the process of law in certain instances precludes the client from gaining an accurate grasp of the implications of a given course of action. However, any such paternalistic actions must be based on particularized knowledge of the client and the client's circumstances.

Unwarranted or unjustified paternalism[63] is always a risk for the client in any professional-client relationship. It is so because of both client vulnerability and inferior knowledge base with regard to the service to be provided. Ozar (1988) has noted "only experts are in a position to recognize whether another is expert in the field" (p.277). While this may be too strong a claim in view of the fact that there are signs of expertise (or lack thereof) which the laity can detect, it does illuminate one foundation for the potential problem of paternalism. I discuss the issue of paternalism again later and in the context of health care

---

[62]It was pointed out to me by Betsy Postow, however, that it is possible to assert (on other philosophical grounds) that paternalism is never warranted even if we grant that the advocate might know what is truly in the client's best interest.

[63]Although Kantian notions of 'autonomy' militate against paternalism it is commonly accepted that there are occasions when this may be justified. For example, it is generally acknowledged as permissible to interrupt a person's suicide attempt at least until such time as one can consider to what extent the individual's proposed action is voluntary. For various views on the extent to which paternalism may be justified see the edited volume Paternalism (Sartorius, 1983).

professional advocacy. It is, however, a somewhat tangential issue to the main purpose of this exposition which is to expose the scope of obligations based on notions of professional advocacy as I have heretofore defined this.

Of course legal advocacy carried out by a law professional qua individual-whose-rights-have-been-infringed is in reality aprofessional self-centered advocacy. A person who is herself a lawyer may well possess the capacity for self-defense of her rights if the rights encroachment is within her area of expertise, but this would not be professional advocacy in that it does not stem from a service commitment to another. A further discussion of aprofessional self-centered advocacy, however, is not helpful to the current analysis.

LEGAL ADVOCACY: AS COMPARATIVE MODEL

Individual versus Societal Advocacy

It might justifiably be asked how this view of the professional advocacy obligations of lawyers assists in our assessment of the advocacy obligations of health care professionals. There are several items of importance to note.

Firstly, it appears that for lawyers the separation of individual advocacy and societal advocacy is relatively sharply defined. By societal advocacy I mean action aimed at addressing such things as the fair distribution of legal

representation. Legal advocates are, generally, not expected to advocate for changes in the framework of justice that obtains for a particular society while enacting the role of advocate. A lawyer may decide to bring her talents to bear in the interests of a particular cause but such an action, if not arising out of her work environment is 'altruistic aprofessional advocacy'[64].

Legal advocates **are,** however, required to further the client's interests against all comers. There is a duty, among other duties, on the part of the lawyer to maintain confidentiality and it is also a priviledge that the lawyer and her client hold against others who would gain advantage by the knowledge. This duty is traditionally much more binding on the legal advocate than it is on other professionals. An illustration of this strict obligation is provided by Glantz (1985) who points to the fact that "the confidentiality of lawyer-client communications is central to the adversary system. Like the priest-penitent privilege, it is older and more ingrained than the doctor-patient privilege" (p. 56).

Glantz does not articulate the difference between obligation and priviledge but it is clear that he sees the lawyer as both being privileged (presumably by society) not to disclose information but also obliged to keep confidences

---

[64]See Chapter Two for discussion of 'aprofessional altruistic advocacy'.

even if keeping these facilitates in some way harm to others. The reason the lawyer confidentiality privilege and obligation is so strict is that protection of rights is assumed to be better served by the adversary system than other systems of justice. The doctor-patient confidentiality privilege and obligation condition, then, is evidently considered (by Glantz) less strong for the physician than the lawyer-client confidentiality condition is for the lawyer. Glantz' concern is with the socialization and education of lawyers. Therefore, his purpose with this argument is not to say anything particular about the medical profession but rather to contrast it with the legal profession.

Support for my reading of the differences between lawyer-client and doctor-patient relationships is supplied by Carson Strong (1993). He has emphasized the point that there is legislation which instructs "physicians to subordinate patients interests to third parties in specified situations" (p. 63). Examples of this include; a mandate to report certain communicable disease to public health authorities, as well as the legal obligation to report incidences of statutory rape. Also the physician is expected to break confidentiality if she regards one of her patients as being a danger to others[65].

---

[65]See Tarasoff v. The Regents of the University of California. 131 California Reporter 14, 1976.

The American College of Physicians Ethics Manual (1992) also notes that "there have always been limits to this advocacy role" (p. 19) of physicians[66]. The advocacy role alluded to is that of the patient-physician relationship. The limits, perhaps, were that the physician was not protected from the consequences of contravening the law[67]. While there is a duty to obey the law, in the Ethics Manual it is asserted that while the "patient's welfare and best interests must be the physician's main concern... The physician cannot be required to violate fundamental personal values, standards of scientific or ethical practice, or the law " (p. 3).

By highlighting the fact of the lawyer's strict obligation to represent the client's interest I do not mean to discount the possibility that there may be tensions created between the dictates of individual conscience and the perceived demands of the professional advocatory role in any given case. For example, destroying the reputation of one's client's opponent may expedite the client's interests while contravening one's personal code of conduct.

---

[66]Of interest is the fact that the 1st and 2nd editions of the ACP Ethics Manual did allow for refusing to abide by the law but in the third and fourth editions this paragraph is omitted.

[67]There may be occasions when a practitioner comprehends that fulfillment of professional advocacy obligations in a given case seems to require contravening the law. Apparently the AMA considers furthering the goal of the profession in such cases to be a supererogatory act.

Interpretation of the dictates of the role in such cases will be variable as they will for members of other professions faced with conflicts or dilemmas.

Determinations of this nature, however, occur within the particular advocate-client role, whereas the type of social responsibilities I am referring to fall either within the jurisdiction of another branch of the justice system such as the judiciary or to the advocate acting outside of her direct representative role. It could be challenged here that there are no real differences in obligation between lawyer-client and physician-patient relationship. That is, it could be said of physicians that their societal responsibilities also fall outside of the direct physician-patient role. I shall maintain, however, that on many occasions physicians cannot promote the health of a client without challenging societal conditions that are presenting obstacles to this goal. I argue more fully to this effect later in the chapter.

It falls to the legislature, not to the individual advocate, to address issues surrounding such ideals as the equal opportunity for all citizens to have their rights defended. Indeed, as pointed out by Glantz (1985) "lawyers are not perceived as decision-makers (although clearly they do make many decisions) but as members of a system designed to make decisions" (p. 55). The system determines what those individual rights are and adjudicates between the

representative adversaries.

This leads to the interesting conclusion that although legal advocates may legitimately demand a certain amount of autonomy regarding how best to defend the client's rights (hopefully based on an assessment of client best interests) they are not accorded the autonomy of deciding whether the client is justified in his demand to have his rights addressed[68]. Thus there are boundaries to an advocate's autonomy in an adversary system.

The scope of a physician's autonomy in contrast to the lawyer's is, or has been, broader. For example, a physician may refuse to provide requested treatment that she thinks will either injure or not promote the patient's health. A physician also uses her expertise to determine what the patient's illness is and based on this judgement she makes treatment decisions. So that for a physician autonomy has typically existed both at the level of determining the problem and in deciding the best way to remedy the problem.

The above argument serves to underscore the notion that societal advocacy is not an expectation of the lawyer as representative in the same way that it is of health professionals - a point that will be defended later in this work. It is neither an obligation as laid out in the Model

---

[68]Of course, it may be objected that a lawyer may decline to take a case, but this obfuscates the point, which is that it is not the legal advocate who ultimately decides whether the client's cause was just.

Rules of Professional Conduct: Client-Lawyer relationship (Windt, 1989, pp. 555-565), nor a societal expectation. Any societal criticisms in this regard tend to be aimed at the larger entity, the legal system itself. However, for medical professionals, advocacy of the individual is inextricably bound to societal issues as will be seen.

What may be concluded from the preceding argument is that the legal advocate while enacting her adversarial role is not, in general, required to also balance her actions on behalf of her client against the needs of society. I shall show presently, that unlike legal advocates, other professionals do have role-related obligations to the society which sanctions their profession. Additionally, since in many branches or situations of legal advocacy lawyers are free to choose their clients, it may appear questionable to what extent individual lawyers have obligations to ensure that representation is available to the underprivileged[69].

The guiding rules for North American lawyers are ambiguous on the above point. Although, in the American Bar Association's Model Rules of Professional Conduct Rule 6.1 of the guidelines for Client-Lawyer Relationships there is a statement admonishing lawyers to "render public interest legal service", this particular declaration is followed by

---

[69]In certain jurisdictions lawyers may be legally obliged to provide some services to the underprivileged.

the disclaimer "Rule (6.1) expresses that policy but is not intended to be enforced through disciplinary process". Thus although, as Kipnis (1986) points out, the sanctions on Lawyers for contravention of many of the 'Model Rules' can be quite stringent, interestingly, laxity in following this particular 'Rule' does not incur penalties[70]. It was pointed out to me that in some jurisdictions there are more severe inducements to provide pro bono services. This 'local' addressing of the problem highlights the ambivalence of the profession about their societal obligations in this regard.

A comparison of the 'Model Rules' for lawyers with codes of ethics of other disciplines, especially the types which guide the health care professions, are also revealing in the following respect: That whereas the legal code is detailed and circumscribes conduct on a variety of issues, the AMA and ANA codes are more vague in their directives allowing some flexibility in interpretation. Also contravention of most of the 'Model Rules' for the conduct of legal professionals is subject to penalties up to and including debarment. The strictness of the rules is designed to keep the balance of advantage between advocate and adversary stable. Thus, contravention of certain rules

---

[70]Although it is not necessary for penalties to apply in order for a professional obligation to exist, (penalties do not play a part in the codes of most other professions) that for lawyers penalties do exist for not fulfilling other obligations raises questions regarding the seriousness with which certain obligations are viewed.

carries stiff penalties. This is in contrast to the sets of rules various health care professions have formulated as 'Codes'. Codes of ethics for such professions serve more as general guidelines. They are subject to interpretation, although, they do serve as reference points for state licensure boards to sanction practitioners.

Advocacy as Role

Secondly, any action undertaken by the legal representative on behalf of the client may be considered an act of advocacy. This is because the express concern of the lawyer as legal advocate is advocacy. Advocacy appears to be synonymous with agency in the legal representative role. It is concerned with speaking for or pleading for the client against an adversary. It may be objected that lawyers also serve as counsellors or advisors. When this is the case the advice generally involves a course of action which may or may not develop into the advocacy relationship. However, my present purpose involves the notion of lawyers as advocates. It is from this particular conception of a lawyer's role that the term 'advocate' as it is used in health care settings is derived.

Finally, the overarching moral value of the legal professional, while acting as representative, is to defend clients with regard to their rights as defined by society and expressed in laws. Thus advocacy of the individual is

the moral obligation of this branch of the profession. It is for the sake of this obligation that other moral considerations may be somewhat weakened. That is, the interests of the client's adversary may be discounted or counted less strongly in the presence of the partisanship required by the role, than they would be by a neutral onlooker.

MEDICAL ADVOCACY AS PROFESSIONAL ACTION

Ambiguities: Individual versus Societal Advocacy

What count as advocacy actions for the physician professional[71] are not quite so clearly discerned. The task of untangling societal versus individual obligations is trickier. It is so, perhaps, because in a sense medical professionals have considered themselves to be both autonomous professional units and constituents of the medical profession. The goals of individual practitioners and the goals of the profession are synonymous; that is, the central purpose of the profession and professional alike is the eradication of disease, or more debatably the promotion of health[72]. Whereas, lawyers as advocates have different

---

[71]'Physician' here should be taken to signify medical doctor (MD) or doctor of osteopathy (DO).

[72]Many allied health professionals and moral philosophers have criticized this idea that contemporary medicine's goal is health. Gadow (1990, 1980) has characterized a common complaint that the medical model seems committed to "science, technology and cure" (p. 41).

ultimate goals than other members of the legal system such as judges. For this reason, the presenting difficulties for medical professionals in promoting the goals of their profession are perhaps more intractable.

Medical Advocacy: A Complicated Concept

Although, in Chapter One various views of the advocacy role of physicians were examined, there did not appear to be consensus regarding the correct formulation of the physician's main purpose. However, it was apparent that several, if not the majority, of commentators assumed as a given that advocacy was equivalent to an exercise of physician agency on behalf of individual patients (e.g., Daniels 1987, Dougherty 1990, Jecker 1990, Pellegrino & Thomasma 1993, Siegler 1985). This advocacy, unlike that of legal advocates, does not necessarily have an adversarial component[73], although it may.

Additional support of this conception, that advocacy is seen by many professionals as an umbrella obligation of the professional-patient relationship, is offered by Jecker and Jonsen (1997) who undertook a qualitative study of physician attitudes. They affirm that findings from the study, which strove to uncover physicians attitudes regarding ethical issues and managed care, showed that many of the interviewed

[73]It may be asserted here that disease and death are the adversaries. But as I shall show this perspective on the meaning of advocacy in health care settings is too narrow.

physicians believed that advocacy is equivalent to "practicing good medicine" (p. 233). On this perspective actions taken as a result of the demands of the fiduciary alliance are those of advocacy. They are so for the reasons given above and earlier. That is, the physician is in a better position than the patient to envision the service required to promote the goal of the profession with regard to the health of the said individual.

The Extent of Actions as Advocacy

It is important at this point to examine more critically what it means to say of physicians that any action stemming from the physician-patient relationship is an advocacy action. Some practitioners engaged in specialty type medicine do not have much patient contact, or have limited contact with a given patient. For those practitioners we may ask, what are their obligations with regard to the individual patient? What proportion of these obligations may be considered those of advocacy? In analyzing these test cases I shall provide support for the notion that for physicians of all specialties, agency resulting from their roles as professionals is equivalent to advocacy.

As a heuristic device I will utilize the focus of medical specialties such as anesthesiology, radiology, and pathology. These are specialties which in virtue of their

specialty loci, in most instances, set more limitations on actual physician-patient interaction than such specialties as oncology, family practice and internal medicine. An investigation of what the obligations such specialists entail should furnish insights for the present enterprise which seeks to discover the mandates and limits of professional advocacy for health care professionals.

The overarching goal of the above specialties equates with the goal of the medical profession in general; that is, the cure of disease or, more debatably as I have noted, the promotion of health. To satisfy tenet number one of the Code of Professional Ethics (1980) the anesthesiologist, radiologist or pathologist should render "competent medical service", and do so with both "compassion" and "respect for human dignity" (APA, 1980). Maintenance of competency involves such things as; remaining current on the latest research findings involving drugs, techniques, and physiological studies. It also involves supervised practice in new techniques and the operation of novel equipment.

Respect for human dignity usually implies recognition of persons as individuals who are, ideally, capable of self-governance. It is a Kantian concept (Kant, 1970). It requires taking into consideration the unique needs of individuals from their perspective as persons with self-governance capabilities. The third component of this initial tenet of the AMA code is the use of compassion in physician-

patient relationships.

Compassion is a complex notion and I will not attempt an analysis of this concept here. However, compassion is generally assumed to involve some sort of understanding of another's suffering, which, surely also involves a recognition of other as individual. This recognition is undertaken from the impersonal stance (Nagel). Acting from compassion would necessarily entail altruism as this was defined in Chapter Two. It will be remembered that earlier in this work, I discussed Nagel's (1991) position that from the impersonal viewpoint others are viewed as individuals with aspirations which, although they may be different from one's own nevertheless, matter to them in the same way one's own aspirations matter to oneself. From the impersonal stance other persons are seen as being as important as oneself. From this perspective the pain experienced by others provides a reason for the perceiver (from the impersonal stance) of the pain to act. The pain, thus, does not just matter to the person experiencing it; it matters impersonally[74].

Professional Obligations: Tenets of 'The Code'

I shall argue, then, that actions taken to maintain professional competency should 'ideally' be conceived as advocacy actions. This is so for the simple reason that they are prior duties of the professional required in order that

---

[74]I owe this clarification to Betsy Postow.

the individual may continue to be so considered. Maintenance of competence, while a requirement both of the professional, and of advocacy, is not sufficient to qualify as professional advocacy. One reason for this is that professional advocacy is concerned with active furtherance of the goal of the profession. However, the professional's competence, perhaps together with other professional attributes such as compassion[75], as part of an action process aimed at furthering the good for a particular patient or for a social good related to the furtherance of the profession's goal should be considered an element of professional advocacy.

Actions are required for reading, attending to presentations at conferences, in dialogue with colleagues, or practicing new techniques under supervision. Those actions may not directly involve any particular patient. Therefore competency is a requirement, or perhaps a moral obligation of the professional as member of the profession, but it is not part of professional advocacy until applied in patient care. But is "providing competent medical service" advocacy?

As validated earlier, it is unquestionable that certain if not most scholars of medicine and many practitioners would assent that this is a minimum criterion for what

---

[75]As these are required to further the goal of the profession in a certain case or instance.

counts as advocacy. Certainly compassion and respect for persons do not always imply actions; they may be foundational states of mind driving: a) the person into the profession in the first place, b) professional advocacy actions in the second place; but they are requirements of medical competency applied in patient care[76].

To push this issue a little further, it might be objected that the actions of a radiologist in reading an X-ray, or an anesthesiologist in rendering a person ready for surgery, or a pathologist in analyzing tissue, can't really be considered advocacy on our view because they seem to be discrete tasks not involving much patient interaction (if any)[77]. However, 'ideally' the physician in fulfilling the goals of the profession does not approach these events as simple tasks. She knows that there is more involved in each case because each case involves a unique individual. The physician role as has been argued is also not one with a purely 'functional' basis.

---

[76]Physicians may not in general subscribe to this view that compassion is a requirement of medical competence applied in patient care. However, this is strongly implied as an obligation in tenet one of the AMA's Code of Professional Ethics (1980).

[77]The reason I have noted the absence of patient interaction here is to draw out the notion that although advocacy **is** the physician-patient relationship when there is interaction, actual encounters are not necessary for the existence of 'professional advocacy'.

Therefore, a morally 'good'[78] radiologist who finds something unexpected on an X-ray will seek further information about the patient. A morally 'good' anesthesiologist will try to get as complete a picture of the patient as possible and will attempt to provide the best anesthesia type or mix for the particular patient based on thorough data-gathering. A 'good' pathologist will be diligent in analyzing tissue samples; she will request additional patient information in those cases where there are questionable results[79].

This description may seem naive and utopian; I don't intend it this way. My main purpose with these examples is illustrative. I wish to show that the ideal of advocacy is the umbrella obligation even for specialists who seem removed from individual advocacy because removed from the individual patients.

An objection could be raised, here, that a pathologist when analyzing the tissue of a corpse cannot really be said to be acting as an advocate. This objection is harder to

---

[78]Although good can have many connotations some moral and some not, I am using 'good' here in the same manner as Cohen (1988). Cohen distinguishes a morally good professional from one who merely uses skills and expertise to accomplish a task. In this sense 'good' is contrasted with 'functional'.

[79]It might be questioned whether the pathologist has to regard the patient as a unique individual to do this. The answer is that if a tissue sample is not easily classified then the patients history is needed in order to discover information which facilitates the tissue classification and therefore informs the diagnosis.

address in the same way that it is more difficult to categorize the actions of physicians who act as 'expert witnesses' in a law suit or criminal investigation.

I will try to answer the objection to the first case in the same manner I would address the relationship of the physician researcher to the research subject who is not intended to benefit from the research. The resulting information is aimed at benefitting other or future patients. As such, it constitutes knowledge-building for the discipline. Neither the research subject nor the corpse are participants in an advocacy relationship. In the first instance this is because the corpse is, in a manner of speaking, beyond need. In the second instance the research subject in this age of informed-consent knows that the research is not intended to help her per se.

The result of this analysis, I believe, supports the notion that any action taken on behalf of a patient by an involved physician is generally conceptualized as an action of advocacy. That is, it is so based on convictions regarding the medical professional's role and its attendant obligations[80]. The challenges that remain, though, revolve around showing the feasibility of this conception given both the nature of the health care environment, and the tension

---

[80]The objection has been raised against determining that **any** action taken on behalf of a patient is advocacy. I claim that it may so be seen because it involves more than a functional view of the task - it involves considerations of the individual as individual.

between individual and societal needs. I will expand the discussion of these factors shortly.

Higher Level Advocacy

The above argument does not exhaust the meaning of advocacy for medical professionals. I shall demonstrate that the advocacy role for physicians necessarily includes an obligation to monitor, criticize, and propose changes in unjust health care delivery institutions or systems[81]. Any redress of disadvantage accruing to individuals who are or may be in need of health care will depend to a certain extent upon public exposure of the reasons for the disadvantage. As I noted earlier such advocacy obligations include preventive and health-promotive endeavors. My assertions in this regard are based on the already defended notion that health care professionals in general are in the best position to recognize inadequacies and inequities in a given system of health care delivery besides being among the

---

[81]I am not arguing here that it is solely up to the medical profession to determine what is just health care provision. This, I believe, requires more than the perspective of medical knowledge, although health care professionals, in general, may be in the best position to articulate problems with the current system and the ramifications of politically-driven proposals. Society's view is neither always reflected in legislative decisions, nor always consensual, for the reasons I gave in Chapter One and later chapters. Determinations regarding what constitutes justice in health care require the input both of other disciplines such as philosophy and sociology, and the various groups within society.

best situated to forecast future health needs[82].

The goal of the medical profession as illustrated in earlier chapters concerns the health of individuals in society and is based on the values of the society. In the US, societal goals based to a certain extent on constitutional assertions, indirectly involve equal opportunity for health care as argued earlier[83]. This may seem to be a controversial claim mainly because as a society we have not acted as if we accept the notion that there should be equal opportunity for health care. Apparent dissonance in values between what is espoused in the constitution and what is evident in the society, as I noted earlier, poses problems for professionals in the furtherance of the goal of the profession. Since the goals of health care professions involve facilitating health for society, it is crucial to discover what this means based on societal values[84].

Daniels, Light and Caplan (1996) in discussing the

---

[82]See Chapter Three, Value coherency and the Survival of the Professions for further previous discussion on this subject.

[83]Daniels, Light and Caplan (1996), as I noted in Chapter Three, have discussed this idea in detail. In answer to the question: "What is the relationship between equal opportunity and the provision of health care services?", they have replied "disease or dysfunction restrict access to life's opportunities" (p.21).

[84]These issues of values ambiguity were discussed in Chapter Three under Value Coherency and the Survival of the Professions. They are explored further in this chapter and in Chapter Five.

failure of the 1994 Health Care Reform debate note that a public discussion of the underlying values for reform never took place. They suggest that "a better outcome in health care reform requires the public to have a clearer picture of the values" (p. 8) involved. I intend to demonstrate that it is part of a health care profession's responsibility to publicize both the values underlying health care provision and the meaning of these values in real terms. For example, if as a society we decide that equal opportunity for health care is something desirable, then the health care professions, moral and political philosophers, and economists have a collective obligation to articulate both what type of system (for example, not-for-profit vs profit and/or a single payor system vs multi-insurer) could provide for this and what benefits and burdens would be involved[85].

The extent of the obligation of physicians to further these goals appears somewhat equivocal, given the prescriptions of their own code and other standards of professional conduct. However, I shall argue that the

---

[85]It is difficult to say what professional obligations exist if society as a whole decides equality of opportunity for health care is not desirable. The grounds for such a decision would have to be analyzed. However, I believe for the reasons given throughout this paper, and in concert with the views of Daniels, Light & Caplan (1996), (which were articulated in Chapter Three and in an earlier footnote to this chapter) that such a decision would be paradoxical based on traditionally espoused US values. Health care professions, if they still exist under such a value system would perhaps have an obligation to articulate for society the outcome such a position entails.

obligation to be advocates of individuals in their care commands a not totally separable obligation for societal advocacy. Further, I shall maintain that lack of attention to the needs of society with regard to health undermines the medical profession's endeavors with regard to individuals.

However although, or perhaps because, these obligations are interrelated they can create tensions when the needs of an individual in a professional's care appear to conflict with societal needs or even with the needs of the professional's other patients. As will be described presently this pull cannot fail to create for the professional confusion and moral dissonance in certain circumstances. That is so, if the assertions of the profession are intended to be taken seriously by its members. Nagel (1991) has analyzed this seeming paradox of focus, pointing out that "the unsolved problem is the familiar one of reconciling the standpoint of the collectivity with the standpoint of the individual" (p. 3).

The problem for medicine, as for other health care professionals, is that both foci, the individual and the collective, require attention of equal concentration but not necessarily simultaneously. The priority focus will differ depending on circumstance.

A Problem of Focus: Society versus Individual

They require equal concentration for several reasons:

Firstly, because the individual patient is an individual in society, she is a social being susceptible to the vagaries of social developments. Social changes affecting an individual include such things as modifications in health care provision arrangements, the collapse of personal supportive structures, and the disadvantages accompanying both economic and functional difficulties. Therefore, she is susceptible to the same catastrophes that befall others in society.

Secondly, the physician also is an individual in society susceptible to all of the potential difficulties outlined above in addition to possessing professional obligations which demand the taking into account of contextual factors. If a physician only attends to the needs of her individual patients and neglects[86] part of the goal of her profession -- societal health -- then she is acting as if she were not actually part of the profession but an independent practitioner. Neglect of the societal aspects of her profession can decrease her power for advocacy of the individual and it also puts an unfair burden on other health

---

[86]It was pointed out to me that to give something a lower priority is not necessarily to neglect it. While this is true,it can be argued that in a busy practice if the needs individuals are always given priority then there will be some neglect of the larger issues. This is so because in a typical practice the practitioner in giving priority to individual patients would be unlikely to have the time or the energy to undertake obligations to society which would in the end benefit individual patients. It is the connection between the two modes that is often not comprehended.

care professionals who must, then, shoulder more of the burden of societal advocacy in order that the goals of the profession be furthered. Additionally, neglect of societal health issues provides opportunities for those with economic rather than health goals to direct or alter the structure of the health care delivery system.

For example, changes in the fiscal arrangements in health care have mandated that many patients change to a different primary health provider disrupting the physician-patient relationship. Neglect of the societal obligations of physicians also has in many instances made the physician ultimately responsible to a non-health care person for directives on what treatments may be provided. The contemporary physician-patient relationship, in short, often consists in a triad: the health-maintenance-company-personnel/physician/patient - relationship.

Since the notion of profession, as has been argued, necessarily involves the capacity for a certain autonomy of action on the part of its practitioners, it follows that if professionals are to be held accountable to society then an equality of focus is necessitated between individual and societal needs where the goal of the profession is the same as that of its individual members[87]. This is because if the goal of the profession is the health of the society, the

---

[87]This qualification was motivated by the case of legal advocates whose goals, as I have noted, differ from the goals of their profession.

notion 'health of the society' means the health of individuals in the society and the means for acheiving this goal are not totally separable.

Thus, obstacles to professional advocacy which often lie outside of the physician-individual relationship, can limit fulfillment of a physician's obligation to this particular individual. Obstacles such as those described above, when left unattended, lead to the dilution of notions of 'profession'. They do so because they encroach on the professional's autonomy to practice her profession. This encroachment on the professional's autonomy weakens notions of accountability[88]. For if the health care professional is not free to exercise her professional judgement what sense does it make to hold her 'accountable' for her actions? I mean accountable in the sense of being criticized for not fulfilling the promises to society as outlined in the discipline's code and as legislated by licensing laws.

However, this tension between the needs of society and the needs of the individual when sincerely considered can highlight critical problems in the current health care delivery system. This is especially true in those notable cases where attention to an individual's needs can provide a temporary solution for this person, but disadvantages others in the system, and/or does not prevent the problem from

---

[88]Accountability for professionals such as physicians and nurses was defined in Chapter Three under the section Professional Accountability.

recurring. It is also important when considering those who either do not have access to care or have limited access to care. This population is growing at a rapid rate and encompasses a large number of working persons. Many of those who have limited access to care will eventually put an unnecessarily costly strain upon society when their health needs reach crisis proportions. They may put a strain on society in a variety of ways such as: a loss of productivity, and the fact that more costly interventions are required when health deteriorates to the extent that crisis care is needed, (which care is still at present provided regardless of ability to pay). Such crises have the potential to also create problems for individual professional-patient relationship in terms of allocation of scarce resources.

A Case of Advocacy Tensions

Suppose, for example, that Dr. Cair has a patient who is experiencing an acute myocardial infarction due to a blockage in one of his coronary arteries. She knows that the hospital at which she has privileges has recently adopted, as a cost cutting measure, the policy of providing only enough nurses in the Coronary Care Unit to care for the patients present at the change of shift. When patients are admitted during the ensuing shift they are allocated out to the nurses who already have the patient load considered

appropriate for adequate care to be given. Adequate care includes early intervention for life-threatening changes[89]. Dr. Cair views herself as obligated to ensure that her patient receives the necessary vigilant nursing attention in order to maximize recovery and decrease mortality or morbidity risk. She insists the nursing supervisor assign more staff to the unit for this shift.

It is a Saturday night and the supervisor is unable to find any suitably experienced nurses who are willing or able to work this extra shift and the hospital for 'cost-cutting' reasons does not have 'on call' nurses. Dr Cair is so insistent that an additional nurse be provided that the nursing supervisor, after consultation with the administrator on call - an individual with fiscal but not health care training, 'borrows' a nurse from another floor. This leaves the medical-surgical floor understaffed. Thereby, the strain has been shifted but not removed.

Dr. Cair has, in this case, seemingly fulfilled her advocacy obligation to the individual. However, occupying four of the newly under-staffed medical-surgical floor's beds are other patients who belong to Dr. Cair's cardiology practice. Two of these patients are hers and the other two are patients of her partners. It is clear that solely

---

[89]There have been various studies to support the claim that early intervention for such crisis events as dysrhythmia, hypotension, and cardiogenic shock, etc. decreases the mortality and morbidity rate of critically ill patients.

attending to the advocacy needs of the individual in this case provides a variety of tensions for the physician. Such tensions are not easily resolved; however, what should be glaringly obvious to the critic is the fact that this type of situation cannot be adequately addressed without attention to questions regarding more systemic causes of the problem.

These more systemic causes may be of several types: 1) lack of health promotion and prevention strategies for the population which if implemented could reduce the amount of expensive technological interventions needed by reducing the incidence and, therefore, sequelae of such things as cardiovascular disease (Healthy People 2000, 1992); 2) institutional obstacles to the provision of adequate staff to attend to patient needs; and 3) the political and economic climate within which health care institutions are configured.

In the case described it is probable that all of these factors are or have been influential to varying degrees, but most obviously that institutional policies are in effect which are based more on immediate economic measures than on the requirements of effective health care provision.

Therefore, included in the physician's[90] professional obligations is the demand to attend to both problematic institutional policies and the matrix within which such policies have grown. The case given above is an example of institutional barriers, however advocacy by professionals might be required at the more fundamental level of criticizing social policies that have led to the problematic institutional situation.

Many other such examples could be given to illustrate the pressure professionals face in continuing to assert the reality of their advocacy roles in the present health care environment. In Chapter Five I discuss in more detail the problems health care professionals face in balancing advocacy obligations in the current health care environment.

Medical Professional Advocacy: A Disingenuous Claim?

Many critics hold the medical profession partially responsible for the current US health care crisis. They note that on one hand it claims its role is advocacy, while on the other hand it has seemed intent on a self-serving maintenance of its monopoly over disease management, a

---

[90]Of course, a higher level advocacy is not solely the physician's obligation; such advocacy is also the obligation of other health care professionals, such as the involved nurses, when this proves necessary to further the goals of that profession. Nurses are subject to perhaps more stringent obstacles to advocacy but I will take up this point a little later. Additionally higher level advocacy may require the involvement of other professionals if the problem concerns health policy matters.

factor which many commentators including Starr (1982, 1992) have described as retarding the progress of health care as a widely available 'good'. Dougherty (1990) in an indictment of the AMA's role in the ongoing health care crisis has suggested that the association's "consistent opposition to proposals to increase access to health care is economic self-interest" (p.282).

While acknowledging that there may be a substantial amount of truth revealed by such analyses, I intend to continue to treat seriously assertions regarding the predominantly altruistic intent of this and the other professions as formulated in their publicly acknowledged 'codes' and 'standards of practice'. At the same time I recognize the complaints of many critics that professions, as organized bodies, exist to some degree for the self-protection and self-promotion of the interests of their members. No matter which version of the purpose of professions one subscribes to, society has a strong interest in holding professionals accountable for the provision of their professed services. It is true that many patients expect their health care providers to be 'advocates' for them in the sense of not giving other interests priority

over theirs[91].

Moreover, the notion of accountability for services necessarily includes recognition of the importance of apprizing potential recipients of the service, when and for what reason the service or services cannot realistically be delivered. Additionally, there is a responsibility in virtue of the esoteric knowledge professionals possess to be instrumental in removing barriers to the provision of the particular service or services as illustrated by the case of Dr. Cair. The instrumentality may take place at various levels but includes empowering persons in society to petition for political change when this is required to further the mutual goals of the profession and society.

A problem with this higher level advocacy requirement, as highlighted earlier, is that although the professional may be best situated to understand the needs of individuals as well as that of the society with regard to their services, they may be dilatory in recognizing the extent and nature of the obstacles to service provision because of the

---

[91]I am grateful for the comments of Nan Gaylord related to this probably widespread belief, among patients and the general public, that their health care provider does and should promote the individual patient's interests over all other concerns. However, the reality of current health care practices illuminates this belief as naive and supports my argument for the existence of obligations of advocacy on different levels. It also supports my claim that society needs to be made aware of the reasons for any incapacity to act solely as individual patient advocate.

anesthetic effects of professional socialization[92]. The remedy for this socialization effect includes a requirement for the profession to be vigilant in its monitoring of movement towards its goal. One of the ways this might be facilitated is via consciousness raising endeavors on the part of the discipline's educators. Additionally, help may be possible via the analyses of the discipline's scholars, and by honest dialogue between the professions and moral and political philosophers whose assistance cannot fail to be valuable in facilitating a clarification of the profession's values and conflicts. The problems wrought by profit-driven managed care interests are presently serving as catalysts for medicine to examine more rigorously the philosophy of their profession. A window of opportunity exists for the various health care disciplines to join forces and collaborate in order that the furtherance of their common goals can be facilitated in the face of economic interests that are not patient-centered.

Balancing Responsibilities:Individual and Societal

It is my intention to demonstrate that advocacy, conceptualized as professional actions stemming from the health care professional-patient relationship, requires a

---

[92]This problem of the anesthetic effect of professional socialization was discussed in Chapter Three under *The Formulation of Professional Codes* and *Problems of Professional Socialization*.

balancing of the health needs of individuals with the health needs of the population. Smith and Churchill (1986) claim that "individual and social ethics do not conflict but are the same obligation with a different focus" (p. 108). While I think there are instances of conflict between these foci in certain circumstances, and that these circumstances pose problems of resolution for the involved practitioners, Smith and Churchill's formulation of the problem faced by primary care clinicians captures the notion that there are two levels of advocacy but that these are related.

Viewing individual and social needs as different perspectives of the same obligation facilitates balancing advocacy demands. For example, one might take care of the immediate individual problem while continuing to engage in efforts to alter societal circumstances from which the individual issue arises. There will still be tensions that are more recalcitrant to resolution and such conflicts will continue to require attention both on the part of health care professionals and on the part of other interested disciplines such as moral and political philosophy.

Contemporaneously, would-be professional advocates must be willing to examine in earnest whether or not a health care system predicated on market values and predominantly economic concerns is really the preferable way to ensure that the American ideal of equality of opportunity is realized with regard to health care needs.

Further, I shall assert that one cannot be an advocate of individuals in need of health care if one is not willing to advocate for just social or institutional policies; and that advocating for just social policies involves collaboration both with other interested professions whose goals intersect with those of medicine's and with interested citizens. Also, required is a perspectival congruence between professions regarding the fact that if professions are to survive contemporarily it is because they are able to persuade society that their primary interest **really** is the good of the society. This claim is being increasingly mistrusted by a public who believes that the bottom line in health care is becoming more and more a financial one. Therefore, any political activism undertaken to preserve the power of the professions must be seen to have as its primary intent the aim of furthering the good of the society.

Smith and Churchill (1986), noted that physicians have in the past tended to neglect the societal implications of their actions. When considerations concerning the morality of actions were made they were more likely to be confining "ethical deliberations to concerns about individual behavior in one-to-one relationships" (p. 85). This narrowness of focus can no longer be an option for physicians if their profession is to survive the destructive actions of profit-motive interests in health care.

Codal Prescriptions

Part of the problem that exists for physicians in broadening their focus is that sometimes there are conflicts between doing what is necessary for a particular patient while at the same time continuing to attend to the impact of given actions on community or society. The simultaneous consideration of both viewpoints can lead both to confusion and to the potential for paralysis with regard to action. Moral guidelines in the form of 'codes' and 'professional standards of action' tend to be, perhaps purposefully, vague and even contradictory with regard to where priority should be placed.

The vagueness of health care professional codes in contrast to the legal profession's 'Model Rules' is not coincidental. I believe this is illustrative of the difference between the scope of purpose of the two professions. The basis for the difference is the seemingly dichotomous mandate of the medical profession to attend both to societal and to individual health needs. This mandate is different than that of the legal advocate whose purpose is confined to the defense of the rights of a given individual or group. Rodwin (1993) has commented upon the fact that "lawyers' roles as advocates help define many of their conflicts of interest" (p. 180). This definition lends itself more easily to proscription of behavior in terms of rules.

However, an examination of the most recent Code of Professional Ethics (AMA, 1980) and the Ethics Manual (1992) of the American College of Physicians (ACP) lays bare inconsistencies in the directives of medicine. On the one hand the physician is expected to serve as the individual patient advocate. In the Ethics Manual it is stated that "the patient's welfare and best interests must be the physician's main concern" (ACP, 1992, p. 3), and in the AMA code there is the assertion that the rights of patients warrant respect. However, on the other hand both the Code of Professional Ethics (CPE) and the Ethics Manual urge the physician to recognize responsibilities to society.

As noted in Chapter One, little direction is available to the morally impelled physician from the tenets of the 'code' regarding how to mediate between such tensions. Indeed, based on statement number VI of the 'Code' a physician is "free to choose whom to serve". If a physician may consider herself free to choose whom to serve does this undermine recognition of "responsibility to society"? What if all physicians chose not to serve the unwashed, the underprivileged or the penurious? It may be assumed by the profession that care of the indigent is covered in other quarters, for example by charity hospitals with salaried physicians or with the provision of medicaid.

However, there is anecdotal evidence to suggest that many physicians do not accept medicaid 'patients' because of

the reduced fees they are paid by this institution. My personal experience with this type of problem comes from visits I have made to nurse practitioner students who are placed with nurse practitioner preceptors at rural primary health care sites. An increasingly frequent complaint from such practitioners is that it is time-consuming, difficult and sometimes even impossible to obtain an appropriate specialist referral for their patients because a given patient's Health Maintenance Organization has no such specialist in the area.

The medical profession must continue to devote attention to such inconsistencies if it is to persuasively demonstrate both the importance and the effectiveness of its mission to society. It is, perhaps interesting to note that the nurses' code of ethics has no such loophole. Nurses are explicitly expected to give care to patients regardless of incidental characteristics. The only exception allowing recusal from care of an individual is for personal moral reasons such as opposition to induced abortion. Even in these circumstances arrangements must be made in order for the patient to receive appropriate care.

One of the greatest threats to the survival of the health care professions is undoubtably the current health care delivery environment. We are well into the era of business and profit-motive-driven interests in health care. There is perhaps little doubt that medicine has been in some

way instrumental in precipitating this move. I don't intend to discuss this instrumentality; it has been debated at length in other works (e.g., Rodwin, 1993, Starr, 1982, 1992, and others).

NURSING ADVOCACY AS PROFESSIONAL ACTION

Ambiguities: Advocacy as Nursing Agency

For nursing, perhaps even more than for medicine, various usages of the term 'advocacy' when this is related to nursing action has led to confusion regarding entailed obligations. It has led to some disagreement among nursing professionals and has confused critics of the profession as noted in Chapter One. The confusions seem to rest on two separate misconceptions concerning the term. One misconception concerns viewing the nurse as patient rights advocate.

This first misconception has arisen because health care professionals have an incomplete understanding of the meaning, origins, and usage of the term within the legal system. This partial conceptual grasp has caused problems because an adoption of the term in health settings has failed to take into account 'advocacy's' ideal origins in law; that is, as meaning a defense of the rights of persons. I have already examined this problem at length in my contrast between obligations of the legal advocate role and the obligations of the medical professional's role. The

foundations of obligations for both of these professions and for nursing were previously examined in relation to individuals and to society.

A second related misconception involves the failure to note that when the term is modified in certain ways the resulting role-related obligations vary depending on the modification. For example, entitling a given nurse 'patients' rights advocate' essentially puts her in a non-nursing role which would therefore incur different expectations on the part of patients or on the part of interested others[93]. Gadow (1980, 1990) has also added a modifier; she has called advocacy for nurses 'existential advocacy'. Gadow's model does describe the nurse-patient relationship and is based on a philosophy of nursing in this regard. It is perhaps a richer account of the nurse-patient relationship than has, generally, been articulated in the nursing literature and reflects certain role-related obligations of the nurse. However, Gadow's model, as a phenomenological account, does not seem able to account for the societal obligations of the nursing profession. For this reason it is an incomplete description of the nurse's role-related obligations.

It thus appears that if the concept 'advocacy' is to

---

[93]I have briefly described Annas' (1974,1990) vision of this in chapter one. However, it is debatable whether a nurse who receives Annas' proposed training and embarks on her new career would be doing 'nursing' as this is defined by the goals and philosophy of the nursing profession.

prove useful as a descriptor of the health care professional's 'ideal' obligations then it requires a modification that speaks more to the scope of these role-related obligations rather than to a circumscribed portion of them. To put this more forcefully, advocacy involves both action taken on behalf of individuals and on behalf of society for the disciplines of nursing and medicine. This is also true of other disciplines for which similar cogent arguments could be made regarding a requirement for societal advocacy. Therefore 'Professional Advocacy' as I have defined it either requires a qualifying modifier or another descriptor. 'Health Care Professional Advocacy' better describes the obligations accruing to health care professionals as a result of their roles as particular professionals.

Nurses Obligations: The Case of Dr Cair

In addressing the involved nurses responsibilities with regard to the previously outlined situation, it is helpful to look at guidelines provided by both 'Nursing's Social Policy Statement' and the 'Code for Nurses'. Nursing's Social Policy Statement (1995) utilizes Pender's (1987) statement, regarding nursing's purpose, to describe what society may expect from the nurse. This quote asserts that nurses "use nursing care to resolve problems or manage health-promoting behaviors" and that they also "help people

identify both short and long-term health goals and act as advocates for people dealing with barriers encountered in obtaining health care" (p. 3). The statement elucidates further "nursing's commitment to the society and the people we serve" (p. vii).

On a more immediate level the interpretive statement of Plank Three of the Code for Nurses affirms that the nurse has a commitment to safeguard the "health, welfare, and safety of the client" (p. 6). These obligations along with those of Plank Four, which involves the nurse's accountability, are illustrative of the profession's expectation of the nurse in both identifying problems and addressing these.

While it is true that these exhortations represent the ideals of the profession and may or may not be able to be met depending on the strengths of constraints to the contrary, they do represent a promise to society. As I have argued earlier, an inability to address these promises, on some level, requires action by the profession. This action may include informing the public of reasons why the profession can no longer provide the services of which it has professed itself capable, and offering assistance in overcoming such barriers as have interfered with nursing's ability to fulfil its obligations.

In the case of Dr. Cair we may ask: What are the involved nurses' responsibilities? At the level of the staff

nurse, her immediate responsibility is to prioritize care for the patients to optimize safety. This may require leaving non-urgent paper work and other non-urgent care to be finished at the end of the shift when relief is available. The nature of critical care is such that several catastrophes may occur simultaneously and critical care nurses are accountable, among other things, for possessing prioritizing skills and for using professional judgement. At the next level the staff nurse has an obligation to address the elements of the situation that are contingent on immoral[94] practices. The nurse on the floor which has now been short staffed has the same obligations as the critical care nurse to use professional judgement in prioritizing care and to address the systemic problems arising from problematic institutional practices.

However, all the involved nursing professionals together with other nursing and health care professionals, whether or not they have actually experienced such situations, on being made aware of them have a collective obligation, as articulated in their 'codes', to criticize social policy arrangements which facilitate institutional

---

[94]By 'immoral' here I mean those choices that have been made independently of the goals of the profession. That is, they (health professionals) have an obligation to challenge decisions based solely on economics or on commercial interests especially as these are made by persons who do not have the specialized knowledge of the health professions regarding what is required to promote or provide health care.

injustices. Such collective action is exemplified by the political activities of the ANA. Thus, the supervising nurse together with involved staff nurses, and the physician, all have obligations to address the policies of the institution in addition to any collaborative obligations stemming from societal promises of the professions.

Although, the case given illustrates an institutional situation, a further problem of concern collectively for health professionals is the recognition that current health care delivery practices are unfair to certain groups of disadvantaged people. Crandall (1990) has challenged health care professionals to pay attention to these problems. He notes that "the occupational role of physicians, nurses and other health professionals gives them special opportunity to observe directly harms caused by denial and delay in gaining access to needed medical services" (p. 48). So finally there is an obligation to assess whether health care can best be provided by the current system.

Williams (1989), a nurse scholar, presents a challenge for nurses that is pertinent also for the medical profession. She writes:

> It must be acknowledged that to change social conditions and relations that limit the possibilities for health, political activism is necessary. Nursing, therefore must be defined in such a way that analysis and action to change the system to benefit the health

of people are essential nursing activities; that is, political activism must be seen as a mode of nursing practice. (p. 22)

CHAPTER FIVE

PROFESSIONAL ADVOCACY: IMPLICATIONS FOR SOCIETAL HEALTH

PROFESSIONAL ADVOCACY AND PRACTICE

Professional Advocacy:An Overview

It has been argued so far that 'Professional Advocacy' is equivalent to professional role. Thus any activity stemming from an individual's professional practice goals may be viewed as that of advocacy. Given that this is so, then, we are justified in further asserting that an understanding of a particular profession's goals with regard to society will reveal both the moral foundations of any advocacy actions and the scope of such actions for an individual professional[95]. The conclusion that there is a moral foundation to an individual's professional practice is derived from the cognizance that this practitioner has undertaken a voluntary commitment to further the goal of her profession upon assuming membership. It is this commitment which makes furtherance of the profession's primary purpose a moral priority in a manner that might not obtain for lay persons.

---

[95]It might be challenged that defining advocacy so widely weakens its moral force. For health care professionals, at least, this is not so. Since the moral obligations of a health care profession concerns furtherance of the goal of the profession, the moral force is provided by the profession's own conceptions of these obligations as articulated in codes of conduct.

Moreover, in the course of this work an explication of the notion that health care professions exist to serve society, and that therefore, the goals of these professions reflect in some way the needs of the society, was carried out. Professions are essentially what Isaacs (1998) describes as social practices. "In social practices persons enter into a collaborative engagement to achieve a common goal or promote a desired good which would be unrealisable at the purely individual level" (p. 4). It has been argued earlier that professions fulfill some sort of need which non-professionals are unable to meet on their own due to a lack of skills, knowledge, or technological expertise.

It is the importance of this overall common purpose of a particular profession with regard to society that has sometimes been treated with less than the seriousness that it deserves. However, it is this purpose which lends coherence to the notion of professions and it is this purpose which should unite professions with similar ultimate goals when obstacles threaten the furtherance of such goals no matter from which particular perspective[96] the goal is generally viewed.

---

[96]Different perspectives concerning health, for example, include those of nursing, medicine, social work, physiotherapy
etc.

Professional Advocacy: The Extent of Obligation

In the course of this present undertaking I have supported the view that professional obligations are wider for some professions than for others. The comparisons made so far in this regard have been between the roles of certain health care professions and the roles of legal advocates. The role of legal advocates, it will be remembered, was chosen as a template for comparing the roles of health care professionals because the term 'advocacy' is believed to have its origins in legal settings. The conclusion reached in an earlier chapter was that by virtue of the fact that the goals of health care professionals are synonymous with the goals of the discipline in general, health care professionals are accountable for a broader range of responsibilities than are legal professionals, at least this is so when lawyers are assuming professional advocacy commitments.

This distinction between 'professional advocacy' for legal advocates and 'professional advocacy' for health care professionals has proved critical to the dual tasks of, a) gaining insight into confusions surrounding the term as this is used in relation to professional role[97], and b) providing coherency of conversation regarding the requirements of professional advocacy. Coherency of conversation proves necessary for both intra and inter-disciplinary discourse

---

[97]See discussion in Chapter Three and Chapter Four.

regarding the obligations of the various health care professions and, consequently their membership, to individuals and society. Discourse of this sort between disciplines which have similar ultimate goals with regard to society, is necessary because, as I noted above, the furtherance of these goals often require that the combined perspectives of the disciplines be brought to bear upon a given circumstance or environmental obstacle in order to provide the most efficacious result for society.

Professional Advocacy: Moral Imperative

The professions who 'profess' their ability to serve the health needs of society are morally obligated not only to address shortcomings in their ability to do this, but also to involve society in the dialogue in this regard. To do so they must first publicize what they are, or are not, able to do and the reasons they are, or are not, able to address shortcomings. I have supported the idea that society in general may not possess the ability to assess the effectiveness of professions in furthering their goals. As proposed throughout this project this is because its citizenry is lacking in the cogent knowledge base to recognize the extent or ramifications of obstacles to fulfillment of a given profession's objective. Since the goals of health care professions at least, are aimed at meeting society's needs it is in the interests of society to

understand when and why such professions may be frustrated in their endeavors.

I have pointed out that if the professions and consequently professionals are not clear about their reasons for existence, their overall purpose, and their obligations to the society which sanctions them, then their continued existence is in jeopardy. But the US society, based on its constitutional philosophy including notions of justice and equality of opportunity, requires the professions to serve the needs of the vulnerable in this regard. By vulnerable I mean in need or potentially in need of the services that the particular profession professes itself obligated to provide. For example, persons vulnerable to rights violations need the abilities of lawyers and virtually all persons have health care needs of some sort.

Professions are required because the interests of the vulnerable, as defined above are not the primary concern in commercial enterprises. As Dougherty (1990) notes "one of the salient aspects of the world of commerce is competition between agents, all of whom are assumed to be motivated by self-interest" (p. 276).

It could be challenged that another mode of attending to the needs of the vulnerable may render professions unnecessary. For example some sort of government entitlement program might accomplish the same thing as a profession by vouchsafing access to health care. However, government

entitlements can only safeguard access to what is available; they are not able to envision the means of meeting the goal of health. They cannot do so because as I have argued throughout this dissertation they do not in and of themselves possess the knowledge and skills demanded.

Service Versus Commerce in Health Care Delivery

Even if it is granted that market or commercial interests may play a role in the efficient cost-effective provision of many human services, the crucial relationship of health care provision to the well-being and flourishing of people necessitates a perspective that is person rather than profit-centered. In the 'market' or commercial arena, as Caplan (1996) writes "there is no such thing as loyalty, fidelity, as a sense of community, as a sense of trust" (p.89); professional accountability[98] is lacking. This is especially true with regard to recent developments in health care provision such as 'managed care'. The ideal of 'managed care' is not intrinsically problematic; however, the

[98]This is professional accountability as defined in various places in this document. It is not merely material accountability in the sense of sanctions of various sorts against a job poorly done but has a moral aspect as articulated in the codes of ethics of the various professions.

existing for-profit forms of it **have** so proved[99]. There are many aspects of for-profit managed care that are troubling. One of the more worrisome aspects concerns the fact that the integrity of professionals in fulfilling their professional advocacy roles is compromised.

The ideal of Professional Advocacy is compromised when, for example, "managed care makes the clinician a gatekeeper, as well as the advocate (because) then the advocacy role collapses" (Caplan, 1996, p. 94). While, I don't believe that the advocacy role need collapse completely because I have defined this role more broadly for health care professionals, making the physician a gatekeeper gives rise to certain conflicts of interest. Nordgren (1995) echoes the concerns of many professionals that, "while a managed care system may eliminate some unnecessary services, its cost-effectiveness also depends on physicians' withholding potentially beneficial care" (p. 79).

However, gatekeepers do not prove so susceptible to constraints on advocacy in other systems. In fact in the British system although General Practitioners act as gatekeepers in so far as this entails mediating specialist referrals, they have "fought to retain their status as independent contractors" (Mechanic, 1996, p. 159). In so

---

[99]Socialized medicine is a form of 'managed care' that might be considered not intrinsically troubling as its primary aim is the fair provision of care. Another form of managed care which is not intrinsically problematic are employee owned and managed not-for-profit enterprises.

doing they have managed to keep some "moral independence from state authority, and theoretically advocacy functions are protected" (p. 159) Mechanic notes. Unfortunately, as he also reports, physicians have not always spoken out against social inequities even though this is recognized as an obligation.

Under for-profit managed care it is thought that the advocacy role collapses because the professional must either succumb to the mandates of the managed care organization at the expense of a particular patient or risk her livelihood. The mandates of certain managed care companies have included such things as limiting patient options and putting pressure on practitioners to conceal information. Essentially the criticism of current US health care delivery practices, including Health Maintenance Organizations and other for-profit managed care entities, involves the idea that there is a wedge placed between practitioner and patient. This is in addition to worsening the problem, that exists for many, of inadequate access to health care.

Professional Advocacy: Societal Values Clarification

Caplan thinks the answer to some of these problems lies in getting society to be clearer about its values. The values underlying the current health care provision environment, as noted early on in this project, are incoherent. The beginnings of redress lies in the

willingness of interested parties to ask "what should this health care system do? What values do we want it to serve?" (Caplan, 1996, p. 95). Caplan seems to think that the answers to these questions can be formulated by professionals and moral philosophers who can then "sell this to the people" (Caplan, 1996, p. 95). I do not endorse some of Caplan's conclusions regarding: what health care provision should look like; how it should be regulated; the notion that there is "nothing intrinsically wrong with trying to make money from health care", or that we should try to "sell" the values clarification package we have come up with to the people"[100]. Nevertheless, I think Caplan has proposed the essential questions to be addressed.

This effort of addressing the essential questions as posed by Caplan is, for the reasons already outlined above, an obligation of 'Professional Advocacy' which accrues to all the so-called health professions. However, the professions and moral philosophy must guard against unwarranted paternalism in the same manner that this should be guarded against at the level of individual or group interests. If the professions are to address society's interests then society must be involved in the debate. Professions are accountable for spelling out the implications of subscribing to one system of health care

---

[100]I believe that it is the people's values in this regard that have to be clarified and that this project should be assisted by professionals.

provision over another, and moral philosophy may be helpful in clarifying values issues, but these tasks cannot be undertaken from the singular perspective of one discipline.

PROFESSIONAL COLLABORATION

Collaborative Ventures

It will take a combined effort of the public, the health care professions, and philosophy to bring about any warranted social change with regard to the manner in which health care is delivered. Isaacs thinks a crucial component of the possible contribution of ethics, which has a tendency to be neglected, is that of the task of evaluation regarding whether we "ought" to continue doing what has been done in the past (1998, p. 14).

In Chapter Four a discrete example was given[101] of circumstances which might most efficiently be addressed by the combined efforts of physicians, nurses and interested or involved others. The example given there, however, concerned an issue of institutional barriers to optimal health under the given circumstances. Much broader examples of barriers erected between societal health issues and health care profession concerns can be provided. As Caplan (1996) points out the health care system "hasn't ever been especially kind with respect to chronic and long term problems and home health care needs, and it is not now" (p.88).

---

[101]See the Dr. Cair scenario.

An example of the paucity of chronic care support is provided by a colleague who was supervising nursing students at a local hospital. The student was asked to 'ready' a patient for discharge home. The patient had suffered a cerebral vascular accident which had left her cognitively unimpaired but with a right sided weakness which made her mobility slow and difficult. Waiting for her at home was her husband who suffered from Alzheimer's disease. He had been temporarily taken care of by a neighbor while his wife underwent hospitalization. Although some visiting nurse service was to be provided, in my colleague's experience this was clearly not adequate for the purpose. The nursing instructor observed "we think we have to be the patient advocate but in cases like this, one has to question who is the patient".

Such health care related decisions, that is to send patients home to problematic circumstances which may further endanger their health, are increasingly being made by persons who have no actual health care experience. The experience many of the 'ultimate' decision-makers in managed care is that of business. That is, it is knowledge regarding the efficient handling of commodities. Additionally, these

decisions are made in a vacuum of unaccountability[102].

It is especially important in the current health care environment, then, that discourse and collaboration between health professionals regarding the furtherance of the goals of both individuals and society with regard to health not be neglected. Disregard of such matters, or divisiveness of purpose between health professions, widens the doorway of opportunity for those whose main interest is profit-making and not the best interests of society with regard to health. Such economic interests find rich fodder for the nurturing of their less than moral projects in the dissension caused by turf battles between professions. Those professions for which the ultimate reason for being is the furtherance of societal health have a **moral** obligation to join their different perspectives in a collective effort to warn, educate and empower the population of concern. This collaboration between professions the ultimate purposes of which coalesce, is required contemporaneously to promote the interests of both individuals and society with regard to health. More than this may be required, of course, if

---

[102]One of the frequent criticisms of corporate managed care systems is that it is difficult to track down who is the decision-maker regarding what treatments or interventions will or will not be covered. Managed care companies tend not to publicize criteria which guide their decision-making tasks. But additionally, since often it is not the health care provider who has the final say, decisions are made outside of the moral framework which ideally guides practitioners. The moral framework provides a component of the notion of professional accountability.

current obstacles are to be overcome; it may take the collective efforts of society, other interested disciplines, and professionals to bring about change.

A further important point regarding the professions that is highlighted by Isaacs (1998) concerns the fact that 'social practices' are "socially embedded inasmuch as they exist within broader social settings and alongside other social practices"(p.12). A reasonable extrapolation from this point is that if certain social practices are viewed as moving towards impotency they are liable to dissolution. If a social practice does not fulfil expectations or needs, then it is reasonable to suppose that it may be lost. The loss of a social practice such as professional health care provision, the bottom line of which is to improve the health of societal constituents, will affect those in society who are vulnerable to this loss of emphasis. As I have argued earlier, loss of attention to health care provision which has as its objective the improvement in the health of the society, possesses the potential to affect any one or all of us.

Thus, it can be concluded more strongly than heretofore that a **moral imperative** exists for both health care professions and their practitioners to collaborate in the interests of societal goals with regard to health. Health care professions may be held accountable for failure to attend to societal goals of this sort. This moral imperative

is derived from the conceptualization of 'professional advocacy' as it has been explicated in the course of this document.

Philosophy and Health Care

In the course of a collaborative venture with a colleague (Grace & Gaylord, 1998), we argued that moral philosophers and indeed philosophers from a variety of traditions have a part to play in assisting the professions to collaborate with each other and with society in order to further society's interests pertinent to the service in question. The medical ethics community has, to date, tended to focus its concerns more on what Buchanan (1991) has termed the "micro" issues at the expense of the larger societal issues. Yet, as a discipline philosophy provides training in those skills most appropriate to assisting in the project of values clarification for the society. Thus, a larger task of moral philosophy, political philosophy and other pertinent philosophical perspectives involves the project of exposing both "what it is that society requires for its overall well-being" (Grace & Gaylord, 1998, p. 15), and whether there is incoherency between the implicit and explicit values of the society as discussed in Chapter One.

Another area where philosophical skills have proven particularly helpful to practitioners is in gaining an understanding of the tensions arising out of professional

advocacy obligations. Professional advocacy it has been argued, is the role of the practitioner. This role involves multiple obligations. These multiple obligations, as noted in Chapter Four, present complex problems of accountability. For example, it is not always immediately clear whether and on which occasions the interests of an individual patient should hold a stronger claim on the actions of the professional than the interest of the society.

Resolving Tensions: Individual Versus Societal Advocacy

Professional advocacy for health care professionals has been described and justified as the role of the professional when this person is undertaking professional activity. Thus, although the emphasis of discussion regarding advocacy activity has traditionally been more geared towards advocacy on behalf of individuals, or perhaps of groups, who are engaged in actual relationships with their practitioners, this is a limited view of advocacy obligations. Advocacy obligations, it has been argued, are much more extensive. However, it is not sound to hold these perhaps different levels of advocacy as mutually exclusive - I have provided evidence to show that they are not. The notion that the so-

called 'partialist' and 'impartialist'[103] viewpoints are necessarily points of conflict arises, in part, from a misconception regarding the scope of professional responsibility.

Conflicts do sometimes arise for practitioners between their obligations to particular patients and obligations to the wider society. This is so for two reasons: 1) The wider society consists in particular individuals some of whom may also be the practitioner's patients as in the example of Dr. Cair[104]; 2) the health of the wider society is also the health care provider's concern. This is, of course, not the only type of conflict the health care provider faces. Conflicts involving a singular patient frequently present themselves to the clinician. Professional integrity demands that in such cases the clinician uses her clinical or professional judgement[105] regarding the best way to resolve

---

[103]Reference to, and further discussion of, this problem of whether the needs of individuals take precedence over the needs of the society with regard to the service provided by the professional was made in previous chapters. The nature of the problem becomes clearer when it is framed in terms of 'Professional Advocacy'.

[104]See Chapter Four.

[105]Professional judgement is that resulting from several factors: 1) knowledge gained in the process of becoming a professional, 2) knowledge gained as a result of practice, 3) continuing education practices, 4) active reflection on personal values, professional values (code) and conflicts between these, and 4) knowledge of professional standards of practice, for example those of the ANA. Additionally it involves some sort of decision-making process. For nursing this is termed simply the "nursing process" for medicine and others it is generally termed "diagnostic reasoning".

the situation. She is accountable for her actions on a moral level; that is with regard to promoting the goal of the profession, and on a regulatory level (via licensing or certification). The moral obligation, however, provides the main impetus for advocacy actions. Therefore moral considerations may sometimes override regulatory considerations. The implications of overriding regulatory concerns would be included as part of the decision-making process.

Accountability

The philosophical assumptions underlying notions of a professional's scope of accountability is expressed in the given profession's code of ethics. In a previous presentation to advanced practice nurses Nan Gaylord and I formulated a model of accountability for nurses which is based on the American Nurse Association's Code for Nurses. The model elucidates facets of professional accountability. These include the foundational assumption of professional competence to provide comprehensive nursing care. That this is the starting point of professional accountability is congruent with my argument throughout this document. Competence includes the pertinent knowledge base to provide care and the capacity to recognize inadequacies requiring consultation/collaboration with appropriate experts in order to provide optimal care. In essence, both clinical judgement

and clinical evaluation are aspects of competence.

Possession of these characteristics are necessary precursors to the role activities of 'professional advocacy'[106] (Grace & Gaylord, 1998). Thus, what was termed 'advocacy' on our model, and which has been clarified in the course of this enterprise as 'professional advocacy' involves attention to both the needs of society and the needs of the individual with regard to the service provided.

It has been pointed out to me that practitioners possess varying levels of both expertise and integrity (Mitchell (1982) has drawn attention to integrity as an important factor in moral conduct). This variance could conceivably prove problematic for notions of professional advocacy because of assertions that individuals who are professionals but who lack expertise in a given area may nevertheless be capable of advocacy on a societal level.

The following example was presented to me as one such objection to the notion of professional advocacy as professional role. It involved the activity of a nursing faculty member who no longer has expertise in clinical nursing but who does engage in advocacy at the societal level with regard to promotion of professional goals. This objection is somewhat difficult to answer. It could be said that since she is a full time educator her goals are more

---

[106]See Chapter Four for further description of prerequisites to professional advocacy.

properly congruent with that of the teaching profession rather than nursing. But it could also be asserted that though she lacks clinical expertise she remains able to access information to provide comprehensive care via others with expertise. This is the same way the problem that specialization of expertise is addressed. A professional understands her own limitations with regard to the problem at hand but she maintains the obligation to provide comprehensive care for her patients via consultation and referrals. Thus, the advocacy action if stemming from this professional's professional objectives is still a role responsibility.

However, if the advocacy action is stimulated by factors external to her professional role responsibilities then it may be considered 'aprofessional, altruistic, advocacy'. That is, it may be so considered unless the intent of the advocacy is primarily self interested in which case it should be considered 'self-centered advocacy'.

Conclusion

My main purpose in exposing the implications of professional advocacy, viewed as actions resulting from the objectives of professional role, was to highlight the notion that the interests of society cannot be ignored by professionals. Many critics have argued that neglect of the societal implications of professional actions whether this

be on behalf of individuals or groups, has facilitated an environment in which profit-motive trumps societal values with regard to human flourishing (Baer, Fagin, & Gordon, 1996; Crandall, 1990; Dougherty, 1990; Gray, 1991; Howe, 1995; Mechanic, 1996; Zoloth-Dorfman & Rubin, 1995). In such an environment professions must prove accountable for their professional promises toward society. One way of doing this is by gaining an understanding of what these professional promises entail.

Crandall (1990) notes the importance of justice in the provision of health care. He maintains that, "health professionals (must) recognize and acknowledge the injustices inherent in current payment and delivery systems and...then move collectively to address the problem" (Crandall, 1990, p. 48). The unique perspective of health care professionals gives them "special opportunity to observe directly the harms caused by denial and delay in gaining access to needed medical services (p. 48)". Moreover, "refusal to recognize these harms and/or failure to act to remediate them represents a dereliction of an *occupational duty* inherent in the healer's role" (Crandall, 1990, p. 48).

Implications for further study.

Clarification of the notion of advocacy as it is used by both by the health care professions, their critics and

commentators will allow for dialogue among these. The realization of shared purposes with regard to justice in health care provides an opportunity to combine forces in empowering society to elucidate and articulate its values openly. The perspectives of moral, political, feminist and other philosophies can prove useful to the task of helping the professions and society illuminate their values with regard to health care including whether the type of health care provision in situ is really the best one for this society.

Further, discourse among the various interested factions serves to bring out the more subtle problems and issues of health care provision to which professionals tend to become anesthetized. It allows for creative collaborative solutions that are perhaps more holistic in nature because they are considerate of different perspectives. Also facilitated by a collective addressing of problems is the power to uncover and publicize forces conspiring to place obstacles between professionals and their goals with regard to individuals and society.

These goals are after all reflective of the needs of individuals as social members of society.

REFERENCES

REFERENCES

Abrams, N. (1978). A contrary view of the nurse as patient advocate. Nursing Forum, 17, 258-267.

Airaksinen, T. (1994). Service and science in professional life. In R. Chadwick (Ed.), Ethics and the professions (pp. 1-14). Aldershot, U.K.: Avebury.

American Bar Association (1908). Canons of professional ethics.

American College of Physicians (1992). Ethics Manual (3rd ed.). Philadelphia, PA: Author.

American Medical Association (1981). Principles of medical ethics revision of 1980. In M. O. Kepler (Ed.), Medical Stewardship: Fulfilling the hypocratic legacy (1981).

American Nurses Association (1994). Position statement on risk versus responsibility in providing nursing care. Washington,DC: Author.

American Nurses Association (1985). Code for nurses with interpretive statements. Kansas City, MO: Author.

American Nurses Association (1995). Nursing's Social Policy Statement. Washington, DC: Author.

Annas, G. J. (1990). The patient rights advocate: Can nurses effectively fill the role (pp. 83-86)? In T. Pence, & J. Cantrall (Eds.), Ethics in nursing: An anthology. New York: National League for Nursing.

Baer, E. D., Fagin, C. M. & Gordon, S. (1996).

Abandonment of the patient: The impact of profit-driven care on the public. New York: Springer.

Baker, R. (1995), The codification of medical ethics. Dordrecht, Netherlands: Kluwer

Bayles, M. D. (1981). Professional Ethics. Belmont, CA: Wadsworth.

Beauvois, J. L., & Joule, R. V. (1996). A radical dissonance theory. London, UK: Taylor and Francis.

Berkowitz, 1. (1988), (Ed.). Advances in experimental psychology, 21. San diego, CA: Academic Press.

Bernal, E.W. (1992). The nurse as patient advocate. Hastings Center Report, 22(4), 18-23.

Bishop, A. H., & Scudder, J. R., Jr. (1990). The practical, moral, and personal sense of nursing: A phenomenological philosophy of practice. Albany, NY: State University of New York.

Bock, P. K. (1994). Psychological anthropology. Westport, CT: Praeger.

Braybrooke, D. (1987). Meeting needs. Princeton, NJ: Princeton University.

Brown, A. D. (1997). Narcissism, identity and legitimacy. Academy of Management Review, 22(3), 643-682.

Buchanan, A. E. & Brock D. W. (1989). Deciding for others: The ethics of surrogate decision making. New York: Cambridge University.

Buchanan, A. (1991). Justice: A philosophical view. In

T. A. Mappes & J. S. Zembaty (Eds.), Biomedical ethics (3rd ed.) (pp. 552-562). New York: McGraw Hill.

Camenisch, P. (1983). Grounding professional ethics in a pluralistic society. New York, NY: Haven.

Caplan, A. (1996). Do ethics and money mix? The moral implications of the corporatization of health care. In E. D. Baer, C. M. Fagin, & S. Gordon (Eds.), Abandonment of the patient: The impact of profit-driven health care on the public. New York, NY: Springer.

Carr-Saunders, A. M., & Wilson, P. A. (1933) The professions. Oxford:Clarendon Press.

Chambliss, D. F. (1996). Beyond caring: Hospitals, nurses and the social organization of ethics. Chicago: University of Chicago.

Chapman, C. B. (1984). Physicians, law and ethics. New York: New York University Press, 1984.

Cohen, E. D. (1988). Pure legal advocates and moral agents: Two concepts of a lawyer in an adversary system. In A. Flores Ed.), Professional Ideals (pp 82-95). Belmont CA: Wadsworth.

Cooper, M. C. (1988). Covenantal relationships: Grounding for the nursing ethic. Advances in Nursing Science, 10(4), 48-59.

Crandall, L. A. (1990). Advocacy of just health policies as professional duty: Cultural biases and ethical responsibilities. Business & Professional Ethics Journal, 9

(3&4), 41-53.

Cristie, R. J., & Hoffmaster, C. B. (1986). Ethical Issues in family medicine. New York: Oxford University Press.

Curtin, L., & Flaherty, M. J. (1982). Nursing ethics: Theory and pragmatics. Bowie, MD: Brady Communications.

Daniels, N. (1985). Just Health Care. Cambridge: Cambridge University.

Daniels, N. (1987). The ideal advocate and limited resources. Theoretical Medicine, 8, 69-80.

Daniels, N., Light, D. W., & Caplan, R. L. (1996). Benchmarks of fairness for health care reform. NY: Oxford University.

Delougherty, G. L. (1977). History and trends of professional nursing: Saint Louis: C. V. Mosby.

Dougherty, C. J. (1990). The costs of commercial medicine. Theoretical Medicine, 11, 275-286.

Fagin, C. M. & Lynaugh, J. E. (1992). Reaping the rewards of radical change: A new agenda for nursing education. Nursing Outlook, 40(5), 213-220.

Flaherty, M. J. (1982). Nursing's contract with society. In L. Curtin & M. J. Flaherty (Eds.), Nursing ethics: Theory and pragmatics (pp. 67-78). Bowie MD: Brady communications.

Flew, A. (Ed.). (1979). A dictionary of philosophy (Rev. 2nd ed.). New York: St. Martin's.

Flexner, A. (1915). Is social work a profession? In Proceedings of the National Conference of Charities and Correction. pp.578-581.

Freedman, B. (1989). Bringing codes to Newcastle (pp. 125-139). In B. Hoffmaster, B. Freedman, & G. Fraser (Eds.), Clinical ethics: Theory and practice. Clifton NJ: Humana.

Freedman, M. H. (1975). Lawyer's ethics in an adversary system. Indianapolis, IN: Bobs-Merrill.

Friedman, E. (1996). Quality managed care: Meeting the needs of high-risk patients and populations. The 42nd Annual National Health Forum Report. Washington DC: The National Health council.

Gadow, S. (1990). Existential advocacy: Philosophical foundations of nursing. In T. Pence, & J. Cantrall (Eds.). Ethics in nursing: An anthology. New York: National League for Nursing. (Reprinted from Nursing Image and Ideals 1980).

Gaylord, N. & Grace, P. (1995). Nursing advocacy: An ethic of practice. Nursing Ethics, 2(1), 10-18.

Glantz, L. H. (1985). Becoming a lawyer: Education and socialization. In J. P. Swazey, & S. R. Scher (Eds.), Social controls and the medical profession. Boston, MA: Oelgeschlager, Gunn & Hain.

Goldman, A. H. (1980). Moral foundations of professional ethics. Totowa, NJ: Rowman and Littlefield.

Grace, P. & Gaylord, N. (1997, May). Advanced Practice Nursing Ethics: Problems, conflicts and dilemmas.

Presentation made at the Tennessee Nurses Association Conference on Advanced Nursing Practice, Nashville, TN.

Grace, P. & Gaylord, N. (1998, April). Transcendental health care ethics: Beyond the medical model. Paper presented at the Society for Health and Human Values Spring Regional Meeting, Youngstown, OH.

Gray, B. H. (1991). The profit motive and patient care : Changing accountability of doctors and hospitals. Cambridge, MA: Harvard University.

Heidegger, M. (1962). Being and Time (J. Macquarrie & E. Robinson, Trans.). San Francisco, CA: Harper and Row. (Original work published 1927)

Henderson, V. A. (1991). The nature of nursing. New York, NY: National League for Nursing.

Howe, E. G. (1995). Managed care: "New moves," moral uncertainty, and a radical attitude. The Journal of Clinical Ethics, 6(4).

Isaacs, P. (1998, April). Social practices, medicine and the nature of medical ethics. Paper presented at the Society for Health and Human Values Spring Regional Meeting, Youngstown, OH.

Jack, R. & Jack, D. C. (1989). Moral visions and professional decisions: The changing values of women and men lawyers. Cambridge: Cambridge University.

Jecker, N. S. (1990). Integrating medical ethics with normative theory: Patient advocacy and social

responsibility. Theoretical Medicine, 11, 125-139.

Jecker, N. S. & Jonsen, A. R. (1997). Managed care : A house of mirrors. The Journal of Clinical Ethics, 8(3), 230-241.

Kant, I. (1970). In A. Zweig (Ed.), The essential Kant. New York: New American Library.

Kepler, M. O. (1981). Medical stewardship: Fulfilling the Hippocratic legacy. Westport, CT: Greenwood Press.

Kipnis, K. (1986). Legal Ethics. Englewood Cliffs NJ: Prentice-hall.

Kultgen, J. (1988). Ethics and professionalism. Philadelphia: University of Pennsylvania.

Lantos, J. D. (1997). Do we still need doctors? New York, NY: Routledge.

Loh, W.D. (1984). Social research in the judicial process: Cases, readings, and text. New York: Russell Sage Foundation.

Maclean, U. (1974). Nursing in contemporary society. Boston: Routledge and Kegan Paul.

May, W. F. (1983). The physician's covenant. Philadelphia, PA: Westminster.

McCullough, L. (1997, March). Medicine and money: Past, present, future. In The ethics of managed care. Kennedy Institute of Ethics Course, Georgetown University, Washington DC.

McLaughlin, B. P. & Rorty, A. O. (1988). Perspectives

on self-deception. Topics in philosophy. Berkeley, CA: University of California.

Mechanic, D. (1996). Changing medical organization and the erosion of trust. The Milbank Quarterly, 74(2).

Mechanic, D. (1996). Reconciling the demand and provision of health services. In P. Day, D. M. Fox, R. Maxwell, & E. Scrivens, The state, politics and health: Essays for Rudolph Klein. Cambridge, MA: Blackwell.

Menkel-Meadow, C. (1996). The trouble with the adversary system in a post-modern, multi-cultural world. Journal of the Institute for the Study of Legal Ethics 1(49), 49-77.

Miller, R. (1980). Rawls and Marxism. In: J. Sterba (Ed.), Justice: Alternative political perspectives, (pp. 81-91).

Mitchell, C. (1982). Ethical dimensions of therapist-patient roles and relationships. In G. J. Agich (Ed.), Responsibility in health care. Reidel.

Nagel, T. (1991). Equality and partiality. New York: Oxford University.

Nagel, T. (1970). The possibility of altruism. Oxford: Clarendon.

Newton, L. H. (1988). Lawgiving for professional life: Reflections on the place of the professional code. In A. Flores (Ed.), Professional ideals (pp. 47-56). Belmont, CA: Wadsworth.

Nightingale, F. (1859). Notes on nursing: What it is and what it is not. London, England: Harrison (reprint, Philadelphia: Lippincott).

Nordgren, R. A. (1995) The case against managed care and for a single-payer system. JAMA 273,(1), 79-82).

Nursing Management, (1995, February). Legislative effect's: What's next? 21-24.

Oxford English dictionary (2nd ed.). (1989). Oxford, UK: Clarendon Press.

Ozar, D. T.(1988). The social obligations of health care practitioners. In J. F. Monagle and D. C. Thomasma (Eds.) Medical ethics: A guide for health professionals. Rockville, MD: Aspen

Parker, J. (1994). Moral philosophy - another 'disabling profession?' In R. F. Chadwick (Ed.), Ethics and the professions (pp. 27-41). Aldershot, UK: Avebury.

Peabody, F. W. (1927). The care of the patient. Journal of the American Medical Association, 88, 877.

Pellegrino, E. D. (1982). Toward a reconstruction of medical morality: The primacy of the act of profession and the fact of illness. In B. Baumrin & B. Freedman (Eds.), Moral responsibility and the professions (pp. 179-203). NY: Haven.

Pellegrino, E.D. & Thomasma, D.C. (1993). The virtues in medical practice. New York: Oxford University Press.

Pender, N. (1987). Health promotion in nursing practice

(2nd ed., p. 27). Norwalk, CT: Appleton Lange.

Peplau, H. (1974/1997). Is healthcare a right? Image: The Journal of Nursing Scholarship. 29(3), 220-222.y

Pirsig, R. (1991). Lila: A inquiry into morals. New York: Bantam.

Primm, P. L. (1986). Defining and differentiating ADN and BSN competencies. Issues, 7(1), 1-6.

Rawls, J. (1951). Outline of a decision procedure for ethics. The Philosophical Review, 60, 177-197.

Rawls, J. (1971). A theory of justice. Cambridge MA: Harvard University.

Rawls, J. (1980). Rational and full autonomy. The Journal of Philosophy,77(9). 515-535.

Reinhardt, U. E., (1992, July). A philosophical framework for health-care reform: Do Americans share a common social ethic? Presented at the 12th Annual Montgomery Dorsey Symposium, Health care reform: Managing the changes that lie ahead, Vail, CO.

Reiser, S. J. (1995). Creating a medical profession in the United States: The first code of ethics of the American Medical Association. In R. Baker (Ed.), The codification of medical morality (pp. 89-103). Dordrecht, Netherlands: Kluwer Academic.

Relman, A. S. (1992, March). What market values are doing to medicine. Atlantic Monthly, pp. 99-106.

Report of the ad hoc committee on titling and entry

into nursing practice (1986). Imprint, 33(2), 49.

Richmond, J. B., & Fein, R. (1995). The Health Care Mess: A bit of history. Journal of the American Medical Association, 273(1), 69-71.

Rodwin, M. A. (1993). Medicine money and morals: Physicians' conflict of interest. New York: Oxford University.

Rogers, P. G. (1986). Milestones in public interest advocacy. In J. Marks (Ed.), Advocacy in health care: The power of a silent constituency. Clifton, NJ: Humana.

Russell, B. (1945, 1972). A history of western philosophy. New York: Simon and Schuster.

Salmon, J. W., White, W. & Feinglass, J. (1990). The futures of physicians: Agency and autonomy reconsidered. Theoretical Medicine, 11, 261-274.

Sartorius, R. (Ed.). (1983). Paternalism. Minneapolis: University of Minnesota.

Sellman, S. (1997). The virtues in the moral education of nurses: Florence Nightingale revisited. Nursing Ethics, 4(1)

Shaffer, T. L., & Cochran, R. F. (1994). Lawyers, clients, and moral responsibility. St. Paul,MN: West.

Shalit, R. (1997, April 24). When we were philosopher kings: The rise of the medical ethicist. The New Republic, pp. 24-28.

Siegler, M. (1985). The progression of medicine: From

paternalism to patient autonomy to bureaucratic parsimony. Archives of Internal Medicine, 145(5), 713-715.

Simon, W. (1986). Ideology of advocacy: Procedural justice and professional ethics. In M. Davis & F. A. Elliston (Eds.), Ethics and the legal profession (pp. 216-272). Buffalo, NY: Prometheus.

Smith, H. L., & Churchill, L. R. (1986). Professional ethics and primary care medicine. Durham,NC: Duke University.

Snowball, J. (1996). Asking nurses about advocating for patients: 'Reactive' and 'proactive' accounts. Journal of Advanced Nursing, 24, 67-75.

Starr, P. (1982). The social transformation of American medicine. Cambridge, MA: Basic Books/Harper Collins.

Starr, P. (1992). The logic of health care reform. Knoxville TN: Whittle Direct.

Strong, C. (1993). Patients should not always come first in treatment decisions. The Journal of Clinical Ethics, 4(1), 63-65.

Twomey, J. G. (1989). Analysis of the claim to distinct nursing ethics: Normative and nonnormative approaches. Advances in Nursing Science, 11(3), 25-31.

Viens, D. C. (1989). A history of nursing's code of ethics. Nursing Outlook, 37(1), 45-49.

Wasserstrom, R. (1986). Lawyers as professionals: Some moral issues. In M. Davis & F. A. Elliston (Eds.), Ethics

and the legal profession. (pp. 114-132). Buffalo, NY: Prometheus.

Wasserstrom, R. (1989). Lawyers as professionals: Some moral issues. In P. Y. Windt, P. C. Appleby, M. P. Battin, L. P. Francis, & B. M. Landesman (Eds.), Ethical issues in the professions (pp. 84-96). Englewood Cliffs, NJ: Prentice Hall.

Webster's deluxe unabridged dictionary (2nd ed.).(1983). New York NY: Simon and Schuster.

Wikler, D. (1991). What has bioethics to offer health policy? The Milbank Quarterly, 69(2), 233-249.

Wikler, D. (1982). Paternalism and the mildly retarded. In R. Sartorius (Ed.), Paternalism, (pp. 83-94). Minneapolis: University of Minnesota.

Williams, D. M. (1989). Political theory and individualistic health promotion. Advances in Nursing Science, 12(1), 14-29.

Windt, P. Y. (1989). Introductory essay. In P. Y. Windt, P. C. Appleby, M. P. Battin, L. P. Francis, & B. M. Landesman (Eds.), Ethical issues in the professions (pp. 1-24). Englewood Cliffs, NJ: Prentice Hall.

Wolf, S. M. (1994). Health care reform and the future of physician ethics. Hastings Center Report, 24(2), 28-41.

Wright, R. A.(1991). Clinical judgement and bioethics: The decision making link. The Journal of Medicine and Philosophy, 16, 71-91.

Zaner, R. M. (1991). The phenomenon of trust and the physician-patient relationship. In E. D. Pellegrino, R. M. Veatch & J. P. Langan (Eds.), Ethics, trust, and the professions, (pp. 45-67). Washington, DC: Georgetown.

Zoloth-Dorfman, L. & Rubin, S. (1995). The patient as commodity: Managed care and the question of ethics. The Journal of Clinical Ethics, 6(2).

VITA

Pamela Grace was born in Manchester, England. Her training as a State Registered Nurse was undertaken at Liverpool's Walton Hospital School of Nursing. In 1974, she moved to the United States where she has held Critical Care Nursing positions in various states including: Florida, Georgia, California, West Virginia, Virginia and Tennessee. Her major areas of nursing expertise are critical care, emergency care, and adult health nursing in primary care. She received a Baccalaureate of Science in Nursing Degree and a Master of Science in Nursing Degree from West Virginia University in 1987 and 1990 respectively. In 1990 she gained Certification as an Adult Nurse Practitioner from the American Nurses' Association. She has held a variety of teaching positions since 1989, both at West Virginia University and at the University of Tennessee, Knoxville. Areas of teaching experience include; Gerontology, Philosophy, Medical Ethics and Nursing. In 1992 she moved to Tennessee to pursue a Doctor of Philosophy Degree, majoring in Philosophy with a concentration in Medical Ethics. She is presently an Assistant Professor in the Family Nurse Practitioner Concentration of the Graduate Nursing Program, College of Nursing, University of Tennessee, Knoxville.