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Chapter 1

The domain of professional ethics

Introduction

In this chapter we examine different meanings of 'professional ethics' in practice and as a subject of study, considering the extent to which the concept of 'profession' still makes sense in the current climate of occupational restructuring and increasing state regulation. We suggest that the rationale for professional ethics in practice derives to a large extent from the conditions of vulnerability, dependence and power in which professional practice takes place, especially in the fields of health and social care. We then explore the nature and function of professional service ideals in grounding professional ethics in the intrinsically valued goods of repairing and maintaining health and social welfare.

A preview: vignettes from practice

The subject matter of this book is ethics in professional life, with a focus on the feelings, thoughts and actions of professional practitioners in the context of their work. The following short accounts are summaries of some of the vignettes discussed in the chapters on specific moral qualities of professional practitioners in health and social care. Most of the vignettes are either written from the perspective of professional practitioners or have a focus on the attitudes, activities and accomplishments of professional practitioners in the context of their relationships with service users, family members, students, other professionals and professional bodies.

1. A nursing student observes a qualified nurse passing a naso-gastric tube (a tube going through the nose to the stomach in order to drain the stomach) on a woman diagnosed with cancer. The student notices the nurse's *patience and sense of humour* as he gains the co-operation and *trust* of the woman.

2. A senior social worker describes supervising a student who is working with a Sikh young man described as having moderate learning difficulties and mental health problems. Police had recently arrested the young man for chasing and possibly assaulting two young women in a park. The social worker feels the young man is facing discrimination on the grounds of his religion and ethnicity, his intellectual abilities and his mental health. The social worker is supporting the student in taking on *the role of advocate* on behalf of the Sikh family.

3. Midwives draw attention to the unacceptable practices of an obstetrician. The inquiry team examining the case states that they 'had difficulty understanding why so few had the *courage, insight, curiosity or integrity* to say: "This is not right" '.

4. A social worker attends a school consultation meeting where children giving cause for concern are discussed. When she asks about the progress of one of the children, a teacher describes the child's mother as 'a waster, she's such a complete drug addict'. The social worker sees this as *disrespectful* and challenges the teacher, who then apologises.

5. A nurse is removed from the professional register of qualified nurses and midwives for falsifying research data. The professional conduct committee hearing the case refers to the nurse's *dishonesty and breach of trust.*

6. A service user with learning disabilities describes her relationship with a social worker, commenting that she was 'the first one who was interested [. . .] she really knew what she was doing, *I trusted her.* She has always given me the right advice [. . .]. It feels good knowing that she is there for me.'

7. A physiotherapist describes the *wisdom* of a senior colleague who always seems to know the right question to ask.

8. A paramedic describes her *fear* as she approaches a mother holding a child who appears dead.

These examples were selected because they provide insights into the qualities of the good professional and give accounts of instances of ethical lapses or situations where professionals reacted to the behaviour of others. It is these kinds of dispositions, situations, processes and relationships that form an important part of the subject matter of professional ethics and on which we hope to shed some light in the course of the book.

What is missing from these brief vignettes is, of course, the broader contexts in which the scenarios are located. These would include further details of the biographies and identities of professional and service user participants (such as life histories, types of professional/service user experience, ethnicity, gender, class and age), the nature and purposes of the organisation for which the practitioners work, the lines of power and accountability, the political, legal and policy contexts. This is one of the dangers of using vignettes – they encourage us to focus attention on one particular situation or incident isolated in time and place. We have tried to include in our longer versions of these vignettes in later chapters as much as we can about the emotions, thoughts or reflections of the people (mainly professionals) whose stories are told, as this is the focus of our concern in writing about virtue ethics. However, the danger of a focus on the individual professional practitioners involved is that the perspectives of service users, the organisational constraints, structural inequalities and societal pressures that greatly influence professional work are left in the background. We will reflect further on this common criticism of virtue ethics in later chapters and at the end of the book.

The nature of professional ethics

As the title indicates, we have located this book within the realm of professional ethics. The term 'professional ethics' has many connotations and is partly influenced by how we define 'professional' and 'ethics'.

'Professions' and 'professional'

One way of understanding the adjective 'professional' is to take it to refer to the activities and approaches of those occupations that can be categorised as 'professions'. There are, however, different interpretations of what counts as a 'profession'. Some writers on professional

ethics view 'professions' quite narrowly as occupations that have certain traits, such as a code of ethics, a service ideal, specialist education and expertise and a degree of occupational control over membership and standards (see, for example, Airaksinen, 1998). This traditional trait-based approach might result in medicine and law, for example, being regarded as full professions; nursing, social work and engineering as semi-, aspirant or pseudo-professions; and child-minding or refuse collection as non-professions. An alternative perspective is to see 'professions' more broadly as occupational groups that make bids for certain kinds of status and power and/or that may move along different trajectories according to conditions pertaining in different countries and different time periods (Johnson, 1972; Siegrist, 1994).

The first view of professions can be categorised as relatively narrow and essentialist, entailing that an occupational group only counts as a profession if it possesses certain key characteristics. The alternative view takes a more historical and developmental perspective, studying changing structures of power, status, control and organisation within occupational groups and between these occupations and the broader society of which they are a part. While the essentialist approach has largely been superseded in sociological accounts of the professions, it persists in some of the philosophical literature on professional ethics, including virtue-based approaches. So although we do not think that the essentialist view of professions has much purchase in the study of the practice of professional groups, it may be required, if only as an 'ideal type' to ground some virtue-based accounts of professional ethics. We will return to this point later in this chapter.

In this book, we do not focus much attention on the debates about what counts as a 'profession', since we interpret the term 'professional' more broadly than simply 'pertaining to professions as identifiable occupational groups'. We regard the adjective 'professional' as being about the roles people play, relationships they conduct and activities they perform in the course of their work in the context of some kind of occupational structure. The occupational structure may take the form of a traditional professional structure as defined by the trait theorists, but it may also take a much looser form – with occupational groups constantly in a process of forming and reforming, with permeable and overlapping boundaries.

If we just take the example of occupations in the welfare and caring field in Britain in recent decades, we can get a picture of the complexity of current practice. We can see a simultaneous process of 'professionalisation' of specific occupational groups, at the same

time as there has been and is a clustering together and state-initiated standardisation of their practices. For example, new groupings have formed around particular types of work, developing their own professional or occupational associations and standards (for example in complementary therapy, counselling, youth work and community development work). Yet at the same time, state regulation of the work of these and all occupational groups has also proceeded, involving a huge national enterprise of defining occupational standards (taking into account the needs of employers, service users, and national social and economic priorities). The increasing emphasis on the role of service user groups in the defining and monitoring of occupational standards in practice and educational contexts is particularly noteworthy. In the case of the larger and more established occupational groups, there has also been a process of reforming or initiating statutory regulatory bodies to oversee these standards, including keeping national registers of qualified professionals.

In the health care field in Britain, the Nursing and Midwifery Council (NMC) replaced the former UK Central Council for Nursing, Midwifery and Health Visiting in 2002. The Health Professions Council, set up in 2001, was recorded in 2007 as regulating 13 health professions including art therapists, chiropodists, dietitions, occupational therapists and physiotherapists. New regulatory bodies covering social work and a variety of types of 'social care work' were established in each country of Britain in 2001. All of these bodies cover more than one occupational group and set standards and monitor practice. They produce codes of ethical practice or conduct which, in some instances, sit alongside or seem to have almost superseded the ethical codes of the professional associations, of which membership is voluntary (such as the British Association of Social Workers).

Despite the challenges to the concept of identifiable professions, the idea of separate professions persists in professional literature and programmes of professional education and qualification. Although in Britain separate professions have been clustered together within occupational groupings for the purpose of developing standards and professional registration, their identities within professional education remain for the moment. Despite increasing trends towards inter-professional and integrated working in practice, and some programmes of inter-professional education, distinct professional identities are still available for practitioners as 'social worker', 'nurse', 'midwife' and so on. Yet at the same time there is no doubt that post-qualifying practice in inter-professional teams

and projects may lead professionals into taking on a variety of roles perhaps once considered outside their profession's remit, and subscribing to team/role specific norms and values. So the situation is fluid and the question remains as to how strong the communities of practice are and can remain in the context of increasing consolidation and control from external institutional and statutory forces.

The example of these changes in the structures of occupational control in the fields of health and social care in Britain illustrates that in studying 'professions' or aspects of professional life, an historical/developmental approach is helpful. This entails seeing the concept of 'profession' as dynamic and shifting, taking into account a range of significant actors and stakeholders (including state, professions, professional organisations, professionals, service users, service user organisations, the media and public opinion).

'Ethics' and 'professional ethics'

The domain of 'ethics' is equally contested, depending upon what ethical theory is held, if any. Broadly speaking, we include within 'ethics' matters relating to the norms of right and wrong action, good and bad dispositions or 'character' traits and the nature of the good life. Whilst some theorists distinguish the domain of the 'ethical' (values concerning the nature of the good life, which may be culturally relative) from the domain of the 'moral' (concerning universal norms of right action), we use the two terms interchangeably in this book. It is important to note, however, that the term 'ethics' is itself used in two rather different ways in the English language: as a plural term denoting the actual values and norms people hold or follow (as in 'Jane's ethics are suspect') and as a singular term referring to the study of norms and values (as in 'Jane is studying ethics [moral philosophy] at university').

This then leads to two understandings of professional ethics:

1. *Professional ethics in practice*: the norms of right action, good qualities of character and values relating to the nature of the good life that are aspired to, espoused and enacted by professional practitioners in the context of their work.
2. *Professional ethics as a subject area*: the study of the norms of right action, good qualities of character and values relating to the nature of the good life that are aspired to, espoused and enacted by professional practitioners in the context of their work.

Professional ethics in this second sense, as the study of norms and values in professional practice, is usually regarded as part of an academic or professional discipline or subject area. Most commonly, professional ethics is seen as a sub-discipline or area of study within moral philosophy, often as a specialism of what is commonly called 'applied' or 'practical' ethics. However, it can be regarded equally as a specialist subject within a particular professional discipline (for example, social work ethics might be categorised as part of the discipline of social work). Whilst these distinctions may seem somewhat pedantic, they do help us understand the rather different approaches that can be found in the literature on professional ethics. The more philosophical literature often focuses either on applying an ethical theory to a professional field (for example, a duty-based approach to medical ethics) in order to test or elucidate the ethical theory or on conceptual analysis with the aim of clarifying arguments and removing confusion (for example, analysing different meanings of 'informed consent' and showing they are contradictory or incompatible). The more practice-based literature, on the other hand, tends to focus on the description and analysis of practical problems and dilemmas or on practitioners' value stances and beliefs, drawing on professionally recognised concepts (such as confidentiality, professional integrity, social control) and sometimes undertaking empirical studies based on methodologies from other social science disciplines such as sociology, anthropology or psychology.

In between these two approaches lies what might be termed a 'hybrid approach' that combines concepts and theoretical resources from both moral philosophy and professional practice disciplines (which themselves draw on the scientific, social scientific and arts disciplines). This is a challenging approach to take. It risks criticism from moral philosophers as 'amateur philosophy', over-simplification or sheer misguidedness. From practitioners and practitioner academics it risks incomprehension or criticism as irrelevant, overly abstract and out of touch with reality. So the hybrid approach, which is, in effect, what we do in this book, requires a degree of judgement about which of the philosophers' fine-grained distinctions and abstract debates are germane and helpful for understanding the practice context and which aspects of a particular theory or approach are not really transferable outside the world of moral philosophy. The terminology of moral philosophers when talking about a concept such as a 'virtue' (which may imply that a virtue is an entity with powers, a possession or an inner state) does not always fit easily with that of other

disciplines (for example, a sociological discourse analysis approach might view virtues as dispositions or performances). This is a book that is essentially about making sense of practice, so our interests and motivations for the study are in the practice field. However, we do develop and draw on a largely moral philosophical account of virtues, modifying and adapting it to our own ends. There is, therefore, a symbiotic relationship between philosophical ideas and vignettes from everyday practice.

Vulnerability, dependency and power

'Vulnerability' is an important concept in ethics generally, and particularly in professional ethics. One of the commonly cited reasons for the need for professional ethics in practice (including written codes of ethics) is that professionals are especially powerful in relation to the users of their services, who are therefore vulnerable to exploitation, abuse or other forms of poor and inappropriate treatment. This is particularly apparent in the case of health and social care, where the users of professional services may be in states of poor health, material poverty, social need or crisis. Yet even in the cases where the service users may be healthy, rich and powerful (users of the services of private doctors, architects, barristers or accountants), the 'professionals' have power deriving from their special knowledge and expertise and perhaps their position as gatekeepers to other services or resources required by the 'clients' or service users. It is important, therefore, for professional practitioners to be very aware of the power inherent in their roles, the vulnerability of the people who use their services and the dependence that service users may have on the professionals.

Thinking of vulnerability in relation to the practice of health and social care, there is a tendency to see it as a concept associated with people who are sick or in social crisis and as negative (leaving people open to harm), yet as MacIntyre (1999) comments, as human beings we are all vulnerable to a range of afflictions at various times in our lives, and our survival and flourishing are in no small part owed to others. Vulnerability and dependency are therefore inevitable facts of the human condition. Furthermore, whilst vulnerability is associated with human fragility and fallibility, leaving us open to harm and mistakes, this very fragility is also associated with a more positive emotional openness, sensitivity and willingness to relate

to others through loving and caring relationships. It is important not to lose sight of the positive aspects of vulnerability in professional relationships, while being equally aware of the potential for damage.

Sellman (2005) usefully distinguishes 'ordinary vulnerability' (applying to all humans) and 'more-than-ordinary vulnerability' (applying to those who are incapacitated in some way by, for example, disability or illness). Elaborating on this distinction he says:

> We are ordinarily vulnerable just so long as we retain the capacity to act in ways that offer us some protection against everyday harms. We are more-than-ordinarily vulnerable when, for whatever reason, we do not have that capacity. So our vulnerability is not merely a function of the extent of our exposure to harm but it is also a function of our capacity for self-protection.
>
> (Sellman, 2005, p. 5)

For people who are extraordinarily vulnerable, feeling vulnerable, that is, being aware of potential dangers and harms, can be a positive protection as it encourages them to limit their exposure to harm. This suggests that it may not always be appropriate for professional practitioners in caring roles to work to reduce people's sense of vulnerability. Professionals themselves will experience ordinary vulnerability, but may also become especially vulnerable in certain circumstances as they undertake their professional roles. In some situations, health and social care practitioners risk catching infectious diseases, experiencing violent attacks from service users or losing their reputations or jobs through making a wrong judgement. Furthermore, when caring for people who are dependent upon them for their health or well-being, professional practitioners themselves become vulnerable. Kittay (1999) makes this point in discussing unpaid, involuntary dependency workers (for example, mothers caring for their children). They are in a unique position to harm or benefit the other people, and this work itself carries a heavy moral load. Professional workers may be in a similar position, although with some degree of institutional and legal protection.

Arguably the most significant positive outcome of recognising and responding appropriately to vulnerability is human flourishing. The ability to respond appropriately to different types of vulnerability (physical, psychological, emotional, existential and ethical) is dependent on the vulnerable person's own characteristics – for

example, on their resilience; on the willingness and ability of others to contribute to or thwart the person's flourishing; and on the nature of the institutions or environments inhabited by the parties involved (are they enabling or disabling?).

The ground of professional ethics: intrinsic goals and service ideals

Drawing on the above discussion, an important element of the rationale for professional ethics could be said to be the provision of a framework for professional relationships in contexts of vulnerability and dependency. Focusing particularly on the power of professionals and vulnerability of service users, it is essential that professionals have a commitment to work for the good of service users in the broader context of the public good. Taking into consideration also the burden of responsibility placed on health and social care professionals, who may find themselves in situations of varying degrees of risk, it also seems important that the roles they take on are actually contributing to a socially valued purpose. This leads to the notion of professions having a core purpose or service ideal that could be described as 'good in itself' underpinning their practices and recognised by professionals, service users and the general public.

Much of what has been written about professional ethics, especially from a virtue ethics perspective, is either explicitly or implicitly premised upon an essentialist view of professions. An assumption is made that there are relatively clearly defined professions with identifiable core purposes or service ideals. This is not to deny that norms and standards of practice and what counts as expertise are constantly evolving and disputed. This may include disputes, for example, about what counts as 'informed consent' and when it can or should be over-ridden; what is 'child abuse' and what is accepted as credible expertise in its identification. However, underlying all this, the argument goes, there is a relatively enduring core purpose or ideal at the heart of each profession that is recognised and lived out by the professionals in their practice. This is a social purpose that is recognised as a good for individuals, families and the wider community or society and is what gives the professions their legitimacy and grounds their professional ethics. For medicine and health care professions generally this has often been identified

as the restoration and maintenance of 'health'. While there is less literature on this theme for social work and social care, the ideal of 'welfare' or 'social welfare' has been suggested for social work.

This view of professional ethics is, perhaps, most clearly articulated in the work of Koehn (1994) in her book, *The Ground of Professional Ethics.* Her main focus is the examination of the moral legitimacy of the professional role. According to Koehn, what grounds professional ethics (as a set of norms, values and practices) is the pledge professionals make to serve some higher good – that is, a good that goes beyond their own self-interest, that focuses on the good of other individuals and ultimately the public good. These sorts of goods or ends of the professions are sometimes called service ideals, although Koehn herself does not use that term. They are regarded as good in themselves (that is, they are not a means to an end, such as individual wealth, group status or social control). In terms of the professions she is studying (medicine, law and the ministry), Koehn (1994, pp.70–71) identifies their good ends as health, legal justice and salvation. While these professions may have other ends or purposes (to provide individual fulfilment or an income for talented people who work as professionals; to sustain a physically and spiritually healthy workforce in order to maintain the economy and generate wealth), the main point is that one major component of the professions' ends is *an end desired for its own sake.* According to Oakley and Cocking (2001, p. 74) a good profession is one that involves a key commitment to a human good, a good that plays a crucial role in enabling us to live a flourishing life.

The idea of a service ideal has been characterised in the literature in several different ways by different authors using different terminology, but broadly referring to similar concepts: the *end* or *telos* of a profession; an *intrinsic goal or purpose*; a *service ideal*; or a *regulative ideal.* Critics have identified a number of problems with these ideas. Beauchamp (2003), for example, taking the case of medicine, argues that it is not possible to see it as having an intrinsic end. The concept of medicine is too ill-formed, he argues, and ordinary language, schools of medicine and legal definitions fail to provide exact boundaries. The same argument would clearly apply to all other professions. However, we could argue that the fact that there are practical difficulties in defining the boundaries of professions does not necessarily mean that the concept of a service ideal or intrinsic end is meaningless. This is only the case if we think the 'ideal' is linked very closely to the core purpose of a clearly identifiable

professional group. The ideals identified above, namely health and welfare, are clearly shared by many related occupational groups.

Another criticism, however, relates to the question of whether we can really separate intrinsic (internal) and extrinsic (external) goods or ends in the way Koehn (1994, pp. 71–76) and others suggest. Surely, argues Beauchamp (2003, p. 32), physicians (and we might add nurses and social workers) can and do provide many important benefits to society and service users that are 'externally' defined – for example, reproductive controls and technologies, occupational health, crime prevention and safeguarding children. If we return to Koehn's account of health as an intrinsic good, she also acknowledges the fact that there are many externally defined goods of medicine of the type Beauchamp lists. The point she makes, however, is that 'at least one major component' of the professions' ends is an end desired for its own sake (Koehn, 1994, p. 71). That is, a profession and the professionals operating within it may have several goals, some of which may not be good in themselves (they may be extrinsic goods), but they must have at least one core intrinsic good at their heart.

Oakley and Cocking (2001, p. 87) make a similar point when they state that extrinsic goods, such as efficiency in resource allocation or respecting service users' autonomy, may also be regarded as goals of medicine (or in our case, nursing and social work). However, these should be regarded as 'side-constraints' rather than the core goals or guiding ideals of practice. A similar argument applies to the aims of individual practitioners for making money or achieving high status – if these were to become the overall guiding ideals or goals of practice, then arguably the practitioner would be a morally flawed occupant of the professional role.

Service ideals as regulative, rhetorical and aspirational

While there are some difficulties with the concept of a 'service ideal', it is important not to take the concept too literally. We might regard its function as an heuristic device (a model offering guidance), or an ideal type of what professional work might be at its best, rather than an accurate representation of what it currently is. Freidson (1983, p. 32), in his study of the professions, describes 'profession' itself as a 'folk concept', which has no single definition and 'no attempt at isolating its essence will ever be persuasive'. This analysis applies equally to the concept of the professional service ideal,

which we could characterise as a myth, folk concept or rhetorical device. This does not mean that it is not in use and not useful. On the contrary, it performs a valuable role in guiding practitioners in striving and aspiring towards individually fulfilling and socially useful professional lives.

A slightly different variation of the service ideal as a 'regulative ideal' is offered by Oakley and Cocking (2001, pp. 25–31), which might help our appreciation of the nature of this rather contested concept. They present this concept in the course of developing a virtue ethical account of medicine and law. Their concept of a 'regulative ideal' is useful in two ways: it is framed in terms of how individual practitioners live out the 'ideal' in practice and it is very clear that the ideal goes beyond what is codified in extant codes of professional ethics. According to Oakley and Cocking (2001, p. 25):

> To say that an agent has a regulative ideal is to say that they have internalised a certain conception of correctness or excellence, in such a way that they are able to adjust their motivation and conduct so that it conforms – or at least does not conflict – with that standard.

On this account, regulative ideals are normative dispositions that may be general in scope or specific to certain parts of life or activities. In the case of professional life, part of being a good nurse or social worker would be to have internalised a conception of what the appropriate ends of nursing or social work are and to be disposed to treat service users in ways that are consistent with these ends. Oakley and Cocking (2001, p. 27) make the important point that regulative ideals can guide and govern professionals' action, without being one of their purposes or motives in acting. Their notion of a regulative ideal includes normative dispositions governing actions according to standards of correctness (that may be codifiable as principles and rules), and standards of excellence that go beyond the merely correct or incorrect (that are not codifiable).

'Health' and 'social welfare' as regulative ideals

Health

Koehn (1994, pp. 71–76) gives an account of 'health' as an intrinsic good in the context of medicine, later acknowledging that if nursing can be conceived of as having an intrinsic good, then this too would

be 'health' (p. 179). If we take serving health to be the central goal of health care professions, then we need to explore in a little more detail what this entails. Koehn (1994, pp. 71–76) offers an account of health as 'wholeness'. She argues that living organisms possess an intrinsic wholeness manifested in their capacity to grow, develop and mature. They preserve a boundary between the inside and the outside of an organism and have some limited capacity to restore themselves to wholeness if damaged (for example, damaged skin tissue is replaced with new in animals; plants will regrow missing roots). As Koehn (1994, p. 72) comments,

> Being healthy seems to mean maintaining the whole. The unhealthy organism is one which has lost the ability to differentiate and maintain the whole with all of its parts.

However, health is more than just being whole, it is also a dynamic process. Koehn speaks of the need for the whole organism to engage in activity to keep individual parts functioning (for example, muscles waste if not used). This is about developing appropriate habits; Koehn describes this as 'well-habitedness', which affects the course of the life we lead. We can choose which habits to develop and whether to prioritise care of our bodies over and above other purposes or choices. This suggests that health involves a balance between inherited or acquired diseases or limitations and the use of our bodies in relation to our plans or desires. If we see health as the balanced functioning of a well-habited whole, argues Koehn, it is clear that it is good both from the perspective of the individual and the wider community. As Koehn (1994, p. 75) comments, 'Health, like life, is good in itself because health is the balanced striving (i.e. living) of an organism with a career. Where there is no health, living is attenuated'. Although this account focuses on bodily health, clearly it could and should be extended to include mental health, given the focus on 'wholeness'.

This account of health as 'wholeness' seems to be based on a particular view of human nature and the function of human beings as whole organisms whose end or *telos* is to achieve and/or maintain this organic wholeness. It is perhaps rather metaphorical and all-embracing and seems almost equivalent to 'flourishing' rather than simply a part of what contributes to human flourishing or well-being. Oakley and Cocking (2001, pp. 76), in attempting to give an account of 'health' that can function as the central goal of medicine, define it more specifically in terms of 'normal biological and psychological functioning'. By this

they mean functioning at a level typical of human beings (of a particular sex, age group and so on). Even when patients cannot be healed or have their health restored, health professionals can serve health in many ways by helping patients to minimise various impairments to functioning or alleviating distressing symptoms. While Oakley and Cocking's account of health is more specific than that of Koehn, it raises a lot of questions about what counts as 'normal' and who defines 'normality'. The use of the concept 'normal' may lead to a devaluation of people with physical and mental states that fall outside the boundaries of 'normal' (for example, people experiencing mental distress, learning or physical disability such as schizophrenia, Down's Syndrome or amputation). For these reasons, Koehn's much broader account of health as wholeness, conceived of as wholeness for this human being, with this career and life course, is more satisfactory, if less specific only to medicine or health care. It leads very easily into the concept of human flourishing, which we will address in more detail in Chapter 2.

Social welfare[1]

Less has been explicitly written on the notion of a service ideal for the social care professions. Airaksinen (1994, p. 8) suggests in passing that 'welfare' is the service ideal for social work. This seems an even broader and more all-embracing concept than 'health'. Several social policy theorists examining this concept (for example, Brandt, 1976; Marshall, 1976) resort to dictionary definitions in a search for enlightenment. Here we find welfare defined as: 'Happiness, well-being, good health or fortune (of a person, community, etc)' (*The New Shorter Oxford English Dictionary*, 1993, p. 3653). This is surely too vague to serve as the core purpose of a profession. As the definition above suggests, the term 'welfare' embraces both individual welfare (the well-being of individual people) and social welfare (which may be regarded as the sum total of all individuals' welfare, or as some form of communal or collective well-being, not necessarily reducible to the sum of individuals' welfare). What is regarded as comprising welfare or well-being will vary between individuals and societies over time, but in this respect it is probably no more problematic as a concept than 'health'.

[1] Banks, S. (2004) *Ethics, Accountability and the Social Professions,* Basingstoke, Palgrave Macmillan, pp. 55–58.

Our use of the term 'welfare' in relation to the social care professions immediately has connotations of 'welfare state', given that many of the professionals work within or are at least mandated and controlled through the social and community services of the local and central state. Those aspects of well-being that are the business of the social care professions tend to be linked to mitigating the ill-effects of poverty, social exclusion, abusive behaviour, individual psychological and physical challenges and promoting community cohesion and democratic participation. This includes a concern with both individual and social welfare. While the individuals of day-to-day concern to most professionals are current service users, professionals also have a significant concern for potential service users, ordinary citizens and taxpayers. Hence 'welfare' includes an element of 'social control', both indirectly in its attempts to mitigate certain social problems at an individual level and more overtly in its work to prevent and challenge child abuse or youth offending, to create cohesive neighbourhoods or to prevent people from harming themselves and others in cases of mental ill health, for example.

However, is 'welfare' specific enough to fulfil the function of the core purpose of the social care professions? Clark (2000), in exploring the core purpose of social work, suggests that welfare is too broad and is shared with other parts of the welfare state. He suggests a more specific purpose as 'to promote the realisation of ordinary life' (Clark, 2000, p. 129). Social workers intervene when there is a discrepancy between the normative (moral) standards generally understood in a particular community and the actual conditions of ordinary life. This is still rather general, but as Clark points out, social work is committed to the indivisibility of welfare – that is, individual well-being encompasses safety, health, housing, financial security and so on. His characterisation of the core purpose is more specific than our dictionary definition of 'welfare'. For Clark's version locates well-being in a social context of commonly accepted standards of what counts as ordinary living. Like Koehn's account of health, this is a very holistic account of welfare. However, by explicitly defining welfare in relation to commonly understood standards of ordinary life in a particular community, this account is less 'naturalistic' than the holistic account of health, since it is not based on a semi-metaphysical account of what counts as a good (in the sense of well-functioning) community. We could interpret this account of welfare as implying that what counts as ordinary living may be disputed and will change over time (that is, it is subject to

ongoing debate and revision within society and the community of professional practitioners). The emphasis on welfare in a social context also leads us to suggest that '*social* welfare' might be a more appropriate characterisation of the service ideal of social work than simply 'welfare'.

Thus, we may conclude that if we had to identify a general all-embracing core purpose or service ideal for the social care professions comparable to those identified in much of the literature on professional ethics for medicine and law, then 'welfare' would fulfil this role. More specifically, this could be construed as 'social welfare', if we want to encapsulate the notion of the promotion of individual well-being in a social context as well as communal or collective well-being.

Concluding comments

Our discussion in this chapter suggests that the concept of identifiable professions with unique core purposes or service ideals does not fit neatly with many aspects of our current experience of professional life in Britain. However, it nevertheless seems possible to suggest that professionals working in health care share a common regulative ideal concerned with restoring and maintaining people's health, and those in social care professions share a core goal relating to the promotion of social welfare. Both these 'ends' are so general and relatively all-embracing that they overlap considerably with each other and encompass a large part of what we might see as human flourishing in general. This suggests that there may be considerable commonality at a general level in what counts as a good health care professional and as a good social care professional, even if the implementation of these ideals in practice differs according to the different circumstances of the work.

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