Autonomy and Trust in Professional Ethics

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Introduction

The title raises many different topics, because the notions of autonomy and trust are both confusing and contestable. Our aim is to reduce the amount of confusion and to clarify the contestability.

Some of this confusion arises partly because professional ethics has been viewed in two conflicting ways: as a special kind of ethics, with its own distinctive features; and as a non-special branch of general philosophical ethics. The second approach is the approach that has long predominated in bioethics, in the form of 'principlism', as constructed by Tom Beauchamp and James Childress (Beauchamp and Childress 1989, 2001). However, some recent work – by Rosamund Rhodes, for example – argues that the ethics of principlism fails to explain the special features of the biomedical professions (Rhodes 2007). Her critique can be applied more generally to the professions, and in this paper we will explore this point further.

Perplexity arises also because there seems to be a tension of some sort between respect for autonomy and trust in professional ethics. Onora O'Neill in particular has argued for this view (O'Neill 2002), as also have Alfred Tauber (Tauber 2003, 2005) and Raymond Tallis (Tallis 2004). The claim is that as talk of autonomy has risen to prominence, actual trust in the professions (especially the biomedical professions) has declined, perhaps to a dangerous degree. Others such as Gerald Dworkin have counter-argued that there is no proof of such tension (Dworkin 2003). Whatever the case, the concepts of trust and autonomy seem essential components of any account of professional ethics, but the way in which these ideas and ideals can be constructively used stands in need of clarification.

It should be made clear that we are not arguing for any particular view of the *content* of professional ethics. We think there is a reasonable consensus on the question of content. We generally agree with the seven-point summary of the general nature of professions proposed by Stephen Pepper.

> The very idea of a profession connotes the function of service, the notion that to some degree the professional is to subordinate his interests to the interests of those in need of his services. This orientation is suggested by the following seven characteristics that define the concept of a profession.
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> 1. A profession is a means of making a living.
>
> 2. A profession is based on specialized knowledge, training, and ability, often requiring intellectual labor and many years of higher education.
>
> 3. The services rendered by the professional, based on this foundation of knowledge and ability, are necessary to individuals at various points in their lives and are frequently of the utmost personal concern (for example, services relating to physical health, liberty, religious salvation, or psychological well-being).

4. Because of the specialized knowledge involved, the quality of the services rendered by the professional is untestable from the perspective of the layman. The individual *needs* the service but is unable to evaluate it, and therefore the individual is *vulnerable* in relation to the professional.

5. The profession holds a monopoly on a service frequently needed by individuals, and as a result wields significant economic power.

6. The profession is largely self-regulated in determining and administering the qualifications for membership and in policing professional activities.

7. Part of the self-regulation usually includes ethical prescriptions that articulate a service orientation. (Pepper 1986: 615)

Pepper's summary implies that professional ethics is a 'special kind of ethics' characterised by a 'service orientation'. Our aim here is to examine what account of general ethics – if any – might underpin this view of professional ethics. In this discussion we will mostly deal with discourse from the biomedical ethics literature. However, as we see it, the questions raised can and do arise in the ethics of any profession.

The formation of modern professional ethics

In giving a background to our topic, we will in part follow Lisa H. Newton who summarises the formation of contemporary professional ethics in this way. In the 1960s and 1970s, ethics ceased to be a private matter to be dealt with in secrecy within each profession. In place of this parochial approach, there developed what she calls 'a cosmopolitan professional ethics', 'an ethics that travels well, whose principles operate with equal force and plausibility in all disciplines'. Certain common understandings emerged.

> The professional was not there just to make money. The professional had a fiduciary duty to the client – or patient, customer, or student – to serve the client's welfare before his or her own. The professional had an obligation to his art, to advance knowledge and to improve practice. And the professional had an obligation to the general public, to protect that public especially from the misuse of the art but also from its neglect. The obligations the professions had in common varied from art to art. For the physician and the lawyer, the welfare of the individual client stood to the fore; for those engaged in education and research, the autonomy and choice of the subject took precedence; for the judge and legislator, justice and equal treatment was the moral touchstone; for the engineer, the safety of the public was 'paramount'. (Newton: 2-3)

The story was one that simply articulated the common understandings of the various professions. But then a new thing happened. The philosophers entered the scene, bringing with them a commitment to finding not just understandings but *ethical principles*. Discussions between philosophers and practitioners uncovered

> … a surprising pattern of agreement, one that the Belmont Report … fortuitously summed up. That report, we recall, gave us the Georgetown Mantra, the Ethical Principles of Nonmaleficence, Beneficence, Justice, and Respect for Persons, which proved entirely adequate for sketching out a framework for the ethics of research

> with human subjects, and has since formed the foundation of interdisciplinary professional ethics. (Newton: 3)

These philosophical ethical principles seemed to be universal. They promised a unified practical ethics. As Newton puts it, 'If practical ethics is cosmopolitan … then ethics is one, all one. Whatever principles we use ought to operate equally well anywhere.' (Newton: 4)

In Newton's view, this amounted to unification at both the philosophical and the practical levels.

> The Principle of Beneficence (Nonmaleficence tucked under its wing) unpacks to entail all of utilitarianism, a complete moral philosophy of the rational adoption of means to serve good ends, the ends being appropriated from the self-description of the profession (quality patient care for medicine, quality products in the hands of those who want them for business, etc.). … Respect for Persons (elsewhere, respect for autonomy) unpacks to encompass the entirety of Immanuel Kant's placement of moral agency at the center of ethics; Justice is grounded in John Rawls. The central political values of Liberty, Equality, and the Pursuit of Happiness are neatly captured in the same formulation, although in reverse order. (Newton: 4)

Rosamund Rhodes takes a similar view, though with some variations. She observes that

> It is now commonplace to view medical ethics as the application of traditional ethical theory to questions of ethics that arise in medicine. … Starting with that assumption, authors [on bioethics] discuss autonomy in Kantian terms, allocation of scarce resources in utilitarian terms, access to health care in terms of rights theory, and professionalism in terms of virtue theory. (Rhodes 2007: 71)

How well has this synthesis of principles really worked? In Newton's view it has worked well.

> We have adopted, then, as the substance of the discipline of ethics, a set of logically independent but generally complementary ethical principles. The major rules that govern the ethics of the professions fall easily under the principles, derived from or grounded in one or more of them. … If ethics is one, we will not find an ethical principle applicable in one profession that violates ethical principles in other professions. (Newton: 4-5)

In this paper, we will contend that – contra Newton – this synthesis of principles has not worked out well. Many other philosophers today also take this view. The most common criticism is that the principlism strategy led to an over-valuation of autonomy, to the detriment of trust (Tauber 2001, 2003, 2005; O'Neill 2002). Our argument will be quite different from this. We will contend that the transition from general ethics to professional ethics was never properly carried through. As we see it, the question is whether professional ethics should be based on its own distinctive ethical understandings or whether it should be derived from general ethics. The principles approach views professional ethics as a branch of general ethics. We wish to argue that, if we choose to take that view, then some new account of the grounding of professional ethics in general ethics is needed.

The problem with respect for autonomy

Each of principlism's principles can be discussed and debated in and of itself, but here we wish to examine their place in the grounding of professional ethics. We will start with the notion of autonomy, which is notoriously difficult to define and debate. Sometimes the concept is used to denote a *capacity* for moral agency. Sometimes it denotes the actual possession of moral rights. In its original Kantian use, it denoted a capacity to bear moral obligations. One common thread in its use today is that it relates to questions of decision-making processes and rights. Its use in bioethics has been in the context of who has what decision-making rights and duties between professionals and their clients. That is the context being assumed hereafter.

The short and simple practical compromise commonly accepted today – though often with some uneasiness – is that the professional has a duty to disclose a suitable understanding of the relevant treatment or service options and to obtain the informed consent to one of them from the client, who therefore has the final say on what action is taken. Here we are discussing only cases in which the client is a competent adult. Our central topic is not this practical compromise but the way in which the concept of autonomy has been used to explain and justify that compromise.

The central problem with the 'respect for autonomy' principle is that it is too general to ground the more specific principle of 'respect for patient autonomy' (or, more broadly, 'respect for client autonomy'), which is what it is intended to ground. Either talk of 'respect for autonomy' simply *means* 'respect for *patient* (or client) autonomy' in this context, in which case we need to argue for this restriction of meaning, or it means respect for *anyone's* autonomy, in which case we should include the autonomy of the professional along with the autonomy of the patient or client, and that they are, *prima facie*, on an equal footing. Respect for anyone's autonomy is another form of respect for persons, and has a long and distinguished history as a general moral principle. Clearly, if we are using the principle in this general sense, then some explanation is needed as to why the patient's decisions or judgements or interests should take precedence over those of the professional, since both professional and client are equally persons and equally capable of making their own decisions. But if we are using it in the first sense – that is, 'respect for autonomy' is being stipulated to mean respect for patient or client autonomy – then we will lose at least some of the moral force that derives from the principle's acceptance as a general moral principle.

Sometimes 'respect for autonomy' is taken to mean 'respect for *rational* autonomy'. Assumptions about rationality are, after all, at the heart of judgements as to baseline competence in patients. (We don't need to elaborate here on the interpretation of the concept of rationality; we are dealing here with a concept put forward by others, not by ourselves; and in any case it is far too large a topic for discussion here.) It seems to us that – contrary to the prevailing view – if we apply this interpretation to professional ethics, we arrive at conclusions not at all favourable to the client or patient. The argument is this. The patient goes to the professional in order to be given the sort of guidance that, in the normal case, only professional people are competent to give. That is, the patient assumes the superior knowledge and rational superiority of the professional, at least in regard to the specific problem for which he or she is seeking assistance. If we then adopt a principle of respect for *rational* autonomy, clearly it is the professional who is more rationally autonomous than the patient, on this specific matter. Any third party observer, having to choose between the advice of the professional and the untutored opinion of the patient, would lean toward following the advice of the professional. In the case of (say) deciding on

behalf of a temporarily incapacitated family member, rational judgement would favour taking the professional view.

Of course, the specific problem – the interpretation of the inflamed appendix, or assessment of the stress-bearing capacities of a mass of concrete, for example – is not the only consideration relevant to the consultation. The client or patient has many other matters to take into account before making a decision. But even in these matters, it is not obvious that the client will make a better decision – one that serves his interests better than other possible decisions – than would be made if he put himself in the hands of the professional. He might do so, or he might not. Professionals are people too, and they can think clearly about the personal aspects of the situation as well as the technical aspects. (Imagine a doctor facing a patient who smokes and drinks too much, eats poorly and to excess, and gets no exercise. Looking at this as impartially as we can, there is little doubt which of these two is best placed to give advice on what the patient should do to manage these obvious aspects of the patient's physical health.) But we don't need to pursue that line of argument.

All we need to contend is that in the *technical* matters that are being considered, the common presumption is that the professional is more rational than the client. Of course professionals can have bees in their bonnets about their favourite treatments, etc. But in general, they are better judges of technical matters than the layperson. If respect for rational autonomy is the principle we are following, then we should follow the advice of the professional. If this claim is accepted, then the principle of rational autonomy supports the professional over the client as the ultimate decision-maker. Of course, the client is making decisions about his or her own interests, while the professional is making decisions about the interests of someone else. But since rationality is essentially impartial, this fact makes no difference to the *rational* quality of their decisions.

Beauchamp and Childress, we think, skate over the problem. They say:

> Because of the unequal distribution of knowledge between professionals on the one hand and patients or [research] subjects on the other, the principle of respect for autonomy entails that professionals have a prima facie obligation to disclose information, to ensure understanding and voluntariness, and to foster adequate decision-making. (Beauchamp and Childress 1989: 73; see also Beauchamp and Childress 2001: 64-5, where a similar view is stated.)

Their conclusion is entirely orthodox but the supposed 'entailment' is far from obvious. By some accounts both parties are 'autonomous', and thus it is not clear who should be the decision-maker; by the standard of 'rational autonomy' the professional is probably 'more autonomous' (if that idea makes any sense) than the client, and thus should be preferred as the decision-maker. No-one argues that only the client is autonomous, or that the client is 'more autonomous' than the professional. Yet some comparative judgement of this sort is needed if Beauchamp and Childress's 'entailment' can carry us to their conclusion.

What we have contended so far is that we need to ground the decision-making rights of the client on some quite different footing than mere appeal to autonomy or rational autonomy.
One way to achieve this is to argue that the crucial factor that makes the decision fall to the client is that it is his or her body that will be operated on, or his or her money and commercial reputation that will be jeopardised if the bridge fails. Of course the professional may also suffer some loss if his poor work causes the client's losses. This may be financial loss or loss of standing, for example. But the primary loss will most often be to the client.

Assuming that the client will have more at stake, we might argue that on this ground it is the client who should have the final say.

This argument seems plausible, as far as it goes. But it has serious limitations. Most obviously, it has the effect of making the professional–client relationship nothing more than a contractual transaction. Nothing in the above story implies that the professional must act from a 'service orientation' or that 'to some degree the professional is to subordinate his interests to the interests of those in need of his services' (Pepper 1986: 615). The story as told has the implication that *caveat emptor* applies. This is contrary to traditional understandings of professional ethics.

In most contractual (exchange) situations it can be assumed that the buyer is seeking the best price and the seller wants the maximum profit, but each sees that he can only get what the other will agree to, and thus a compromise is reached (or else no deal is done). Assuming that the bargaining power of the parties is roughly equal, and excluding the case of fraudulence, a rough-and-ready form of justice emerges, a justice calculable in terms of returns and comparable in terms of exchange.

In a professional-client consultation, some of this dynamic may be operating, but we generally agree that this picture misses out some of the vital features of the situation. We won't try to argue this claim here, since we think it is widely accepted. Contracts have many valuable features, but they don't well capture the characteristic feature of the professional situation, which is that the professional puts a body of knowledge and practical expert judgement at the service of the client who is in need of just that sort of service and cannot supply it for himself. In this way a relationship is forged that goes beyond that of a contract. As Alfred I. Tauber (speaking in a medical context) says, 'no contract can exhaustively predict or cover the needs of patients, and the kinds of services rendered by physicians in terms of empathy or compassion can never be specified' (Tauber 2005: 136).

Socialised autonomy

One tempting approach which is sometimes adopted is to modify by 'socialising' the concept of autonomy. Tauber, for example, takes this line. He contends that

> 'autonomy' may be regarded as a primordial product of social relationships, and not necessarily only a consequence of a severe individualism … According to 'relational autonomy', isolated persons are not only incomplete individuals, but their isolation beleaguers them with burdens that actually impede their self-actualization. … This insight highlights a fundamental social fact: no one is fully autonomous, inasmuch as everyone relies on a vast social network to provide goods and services, and each of us enjoys (or regrets) complex and numerous personal relationships. … So part of the murky philosophy enveloping 'autonomy' is cleared by recognizing that none of the criteria defining autonomy precludes interdependence: (1) decision-making must be one's own, and free of coercion; (2) to fulfil the first requirement, one must critically reflect on one's choices to ensure that they are solely self-motivated; and (3) autonomous choices bequeath responsibility for those choices. (Tauber 2003: 489-90)

Yet we may agree with all of this and still not see how exactly it helps explain the foundations of professional ethics. Having introduced 'interdependence', Tauber comments

that 'The dependency of patients is a paramount case of such reliance on others' (Tauber 2003: 490). This is true, but it fails to distinguish between dependence and interdependence. The patient is a paramount case of *dependence*. There is normally very little the patient can do to relate interdependently with the medical specialist, beyond paying the bills and expressing gratitude. (In the extreme case, the specialist may have saved my life!) And this kind of thing is true of the normal professional situation, which is one of dependence, not interdependence. A general social ethic of interdependence is, very plausibly, superior to one of atomistic individualism, but that general social ethic is also too general to capture the specifics of the professional situation.

Principled autonomy

In bioethics, according to O'Neill, autonomy 'is generally seen as a matter of *independence*, or at least as a *capacity for independent decisions and action*' (O'Neill 2002: 23). In her view, this is a far too narrow understanding of the concept.

> Those who insist on the importance of informed consent in medical practice typically say nothing about individuality or character, about self-mastery, or second-order desires, or about any of the other specific ways in which autonomous choices supposedly are to be distinguished from other, mere choices. In short, the focus of bioethical discussion of autonomy is not on patient autonomy or individual autonomy of any distinctive sort. What is rather grandly called 'patient autonomy' often amounts simply to a right to choose or refuse treatments on offer, and the corresponding obligations of practitioners not to proceed without patients' consent. (O'Neill 2002: 37)

O'Neill argues for an ethics of autonomy, but one very different from the versions given above. Hers is an ethics of '*principled* autonomy'. In this approach, ethics starts from obligations and not from rights. It is a Kantian, rules-based approach.

> The background ethical arguments for medical practice and the role of informed consent within that practice can be sketched as follows. Commitment to principled autonomy – that is, commitment to principles that can be adopted by all – entails setting aside destroying, injuring, coercing or deceiving others, and rejecting indifference to others' capacities to survive and to act. (O'Neill 2002: 149)

O'Neill's Kantian approach starts from the obligations that arise from 'principled autonomy'. The patient's autonomy implies a correlative obligation in the professional. This is how the professional's ethical obligations arise. These obligations entail that patients enjoy correlative rights to non-coercive, non-deceptive professional care. By following this ethical approach, she believes, we can hope to strengthen and rebuild trust in the professional-patient relationship. 'Whereas individual autonomy is constantly in tension with relations of trust, principled autonomy provides a basis for relations of trust' (O'Neill 2002: 97). 'Setting aside deception entails a commitment to trustworthiness. Trustworthiness is expressed through institutions, practices and actions that it is reasonable for others to trust.' (O'Neill 2002: 149)

Nevertheless, she too is seemingly using the argumentative strategy that we have been criticising. The general principles of principled autonomy apply as much to the patient or client as to the professional. How then can there be any distinctive obligations on the

professional? We can not see that she has answered this question. Rather, she seems to be doing what we are arguing against. She has selected a general ethics – classical Kantian ethics, in this case – and applied it to one part of the professional situation so that she will arrive at an outcome that she has decided in advance needs to be reached. The intended outcome is a more trusting partnership between the professional and the client. Desirable though this no doubt is, the argument strategy is flawed.

The relevance of non-maleficence and beneficence

The 'principlism' model proposes that biomedical ethics should be governed not just by 'respect for autonomy' but also by principles of non-maleficence and beneficence. That is, the medical professional should be guided by the idea of least harm and greatest benefit to the patient. (Cost considerations also come into the picture, but we will put these aside as not relevant to the argument we are exploring.) We wish now to explore how far these principles might be relevant to professional ethics generally.

Principles of least harm and greatest benefit seem sensible and safe, when stated baldly and in the abstract. What objections could they possibly raise? Further, these two principles seem to have a desirable feature that the principle of respect for autonomy lacks. Respect for autonomy, being a general principle, applies in both directions, from professional to client and from client to professional. And, as we have been arguing, this seems to defeat its ability to serve as a workable ethical guideline for the professional situation.

But non-maleficence and beneficence look as though they apply to how the professional should treat the client, and not to how the client should treat the professional. It is the surgeon who will be operating on the patient's brain, and who will need to be focused on doing least harm and greatest good.

However, this picture is a little too simplified. There are two phases in the professional-client relationship. The first is the contracting phase, when the treatment or service is decided upon; the second is what we can call the performance phase. In the first phase, typically, the ethical professional will propose the treatment or service that he or she sees as causing the least harm and offering the greatest benefit to the client, or will offer a short menu of available options with one of them the option preferred by the professional as being in the patient's best interests. But the principle of respect for autonomy complicates this picture, since (as we have seen) the client may have a different view of these matters and may choose an option at odds with the professional's recommendation.

Non-maleficence and beneficence, as judged by the professional, do not settle the matter in the first phase, since the patient or client has his own view of what constitutes least harm and most benefit. And by general consent the professional may not impose his or her view of this on the patient or client, if this means overriding client autonomy (putting aside cases where the patient or client is incapable of exercising reasonable judgment).

If respect for autonomy is a one-way and ultimate principle (as is assumed in the dominant principlist model), then the patient or client has the final say on what treatment or service he will receive. At the least, he chooses which of the treatments on offer is to be performed. In that case, for all practical purposes 'non-maleficence' and 'beneficence' are whatever the patient or client deems them to be. (Of course beneficence and non-maleficence are important also as motives and as expressions of character, but here we are focused on

actions.) The professional's judgement on these principles is decisive only to the extent of defining the options for action. His or her motives are not able to sway patient decisions, and although character and manner may have a persuasive influence, this does not remove autonomy.

In the second phase of the professional-client relationship – the performance phase – two different ethical elements are at work. The professional must carry out the treatment as agreed upon. That is a contractual obligation. But he must carry it out still mindful of the patient's best interests, following the least harm and most benefit principles, following a 'service orientation' (in Pepper's terminology).

Returning now to our broader argument, we have seen that respect for autonomy seems to be the predominant ethical consideration. But if this is so, then the problem of how to make the respect for autonomy principle work coherently in a professional situation comes back into the frame. The principles of non-maleficence and beneficence do nothing to lessen that problem. And, as we have argued, the respect for autonomy principle lacks coherent application because it fails to show *why* the patient or client has (or should have, if he hasn't actually) any special decision-making rights.

Trust and professional ethics

In reaction against what is seen as the excessive elevation of the principle of respect for autonomy, some ethical commentators are now attempting to modify the autonomy outlook by giving serious weight to the notion of trust (Tauber 2003, 2005). Like Onora O'Neill, they see trust as having been weakened by the emphasis on autonomy, and they fear that this weakens the general social framework within which the professions operate, to the detriment most of all of the patient or client. How plausible this supposed tension between autonomy and trust is does not need to be analysed here. (On this see Dworkin 2003.) Our aim is rather to think through how the concept of trust can and can not be used in the context of understanding professional ethics – as distinct from 'everyday' ethics.

Three observations come immediately to mind. One is that trust is not a principle. It is not at all like respect for autonomy, non-maleficence or beneficence. By this we mean that trust is not even remotely a rule for guiding action. It is, rather, an attitude or predisposition. Social life would be impossible if we were not normally willing to extend trust to others, but that extending is usually provisional. I can be predisposed to trust you, but I may in fact not trust you at all and I may act towards you with a very cautious distrust, because although I am disposed to trust you I have chosen to suspend that disposition.

Second, the concept of trust is paired with the idea of trustworthiness. We can't explain the values implicit in the idea of trust without also explaining what trustworthiness is and why it too is valuable.

That leads to a third point. Often, perhaps typically, trust needs to be earned. Trust is earned by a demonstration of trustworthiness. Trust can be given freely, but incautious trust is easily abused.

If we try to derive a principle from the idea of trust, the outcome might be something like this: 'Trust those, and only those, who have shown themselves to be trustworthy'. That is, don't be too distrusting or too trusting. But this is not a principle that cuts much ice. If our

concern is that the professions are losing too much of the general public's trust, we can't just say: 'trust them, they know what they're doing'. But if we accept that trust should be proportional to trustworthiness, then we have the difficulty of demonstrating that trustworthiness. This can be done, in part, by trying to dispel bad arguments used to support an excessively negative public image of the professions (as is done in part by Tallis: 2004). But how much can be done to make the case for greater trust? The problem lies in explaining what the profession does. This can't be well explained without going into the knowledge and research base of each profession, which is in its nature difficult territory.

This last point helps to bring out a key point about the professions, pertinent to what constitutes professional, as distinct from general, ethics. Professionals possess useful knowledge, and useful knowledge is power, so – relative to the general public – professionals possess power, both in general and in the particular relationships between client and professional. If we (the general public) are to trust professionals, we will be trusting a body or a person more powerful in some ways than ourselves. The trust will be asymmetrical. (This is the fourth point in Pepper's seven-point summary of the nature of a profession above; see Pepper 1986: 615.) So the question is not one of trusting those who are demonstrably trustworthy. Rather, it is one of trusting those whose trustworthiness is not easily verified and who could be in a position to do considerable harm, intentionally or unintentionally, as well as much good. The trust required is somewhat like that of a child towards a parent. Note that we are not questioning the general trustworthiness of professionals. Our focus is only on whether this trustworthiness can be validated by argument. Clearly, the stakes are high and any argument for this contention is going to be difficult to construct.

If the professions are to function at all well, trust in them is undoubtedly necessary. As Tallis observes of the medical case, 'In the end, given that the understanding of the nature of disease and its treatment, and the rationale for treatments, requires quite a bit of training, and given, too, that the rational assessment of risk is not very well developed in many of us, there will be an irreducible element of trust in agreeing to a treatment' (Tallis 2004: 55). He also argues that in many respects the power of the medical profession is illusory: today 'doctors are relatively disempowered – more cog-like that god-like' (Tallis 2004: 75). 'Medical practice requires an almost superhuman grace under a multitude of pressures' (Tallis 2004: 77; see 74-108). We can accept all of this, and accept that something similar is true also in other professions. Even so, it may also be equally true that professional failures commonly have serious consequences for the unfortunate and vulnerable client.

The asymmetry in power and knowledge is the key reason why a professional consultation is not the same, ethically speaking, as an ordinary contractual situation. But the discussion above suggests two things about the ethics of professional consultation. First, we can not derive a practical ethical *principle* of trust from the concept of trust, since such a principle would require some demonstration of the trustworthiness of the professional, and that is what we are unable to give because of the inherent intellectual difficulties involved. Bernard Williams observes that trustworthiness is 'the disposition of an agent to be reliable, not in the sense that you can rely on him to help you (that is a different disposition, helpfulness), but in the sense that he will help you if he has told you he will help you or, perhaps, if he has led you to believe that he will' (Williams 2002: 92). On this account the 'helpfulness' that is a 'service orientation' can't be derived even from trustworthiness. Second, the central issue is not trust as such but trust between unequals. Being generally willing to trust those I regard as my equals does not necessarily imply that I will be or should be equally willing to trust those who exceed me in power and knowledge. In many cases it would be quite rational not

to trust such people. A problem for professional ethics, then, is to show why someone who will trust his equals but who will not so readily trust those who have greater power should trust the professional elite. This is another version of the problem of the transition from general ethics to professional ethics. A general ethics of trust, if one could be constructed, need not go far towards supporting the kind of trust needed in the professional context.

Professional ethics and general ethics

The question we have been exploring is how, if at all, is professional ethics grounded in general ethics? Discussions of the basis of professional ethics seem to be scarce. H.A. Bassford's discussion of how to generate an ethic for any given profession is worth noting here.

> One should first study the practice of a profession to determine its basic purposes. This will allow the statement of the basic role-specific norms of that profession. One should then look and see whether there are subsidiary role-specific norms necessary to accomplish the goals expressed by the basic norms. … Finally, it is important to see how the given profession's values fit into the general scheme of human values, and to look at how the role-specific norms of the profession should interact with general moral norms. … It would be illusory to think that the norms of any profession could be completely and finally stated. (Bassford 1990: 131)

The task of seeing 'how the given profession's values fit into the general scheme of human values' is the task we think requires fresh examination.

One common answer, the answer of principlism, seems to be that professional ethics takes elements of general ethics – respect for autonomy, beneficence, and non-maleficence – and fits them into the professional situation. We have argued that there is little or no logic to the way in which this fitting has been carried out. Another common answer is to take the general notion of trust and try to make trust serve as a working guide to the professional situation. On this we have argued that trust cannot be made to work in this action-guiding way. It is simply too general.

What is the alternative to basing professional ethics on general ethics? Rosamund Rhodes suggests an answer for the medical case.

> To understand the social role of medicine and its ethics, it is important to recognize that the medical profession is a social artefact created by giving control over a set of knowledge, skills, powers, and privileges exclusively to a select few who are entrusted to provide their services in response to the community's needs and to use their distinctive tools for the good of patients and society. (Rhodes: 2007, 83)

Her contention can be applied to the professions generally. On this view, a profession should be seen as a socially-sanctioned practice. From this we can conclude that the *obligations* of the professions arise from a contract between society at large and the professions – and not from the relation between the professional and the client. This might be described as a kind of 'fiduciary ethics', and it may be a better way to approach the problem we have been diagnosing. (The fiduciary approach can be found in Beauchamp and Childress, sitting alongside their more Kantian approach. See Beauchamp and Childress 1989: 73, where they quote Angela Roddey Holder, 1975: 225; and Beauchamp and Childress 1989: 312-3.) It

might provide what Newton calls a 'cosmopolitan practical ethics', one that is equally at home in all of the professions, with principles that 'operate equally well anywhere' (Newton: 4). However, that is an idea to be explored on another occasion.

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