PUBLICATIONS OF
THE UNIVERSITY OF EASTERN FINLAND

Dissertations in Social Sciences and Business Studies

UNIVERSITY OF
EASTERN FINLAND

SALLA SAXÉN

Ethics in Professional Discourse

An exploration of moral uncertainty and the diversity of ethics in healthcare professions

Ethics in Professional Discourse

An exploration of moral uncertainty and the diversity of ethics in healthcare professions

Salla Saxén

Ethics in Professional Discourse

An exploration of moral uncertainty and the diversity of ethics in healthcare professions

Publications of the University of Eastern Finland
Dissertations in Social Sciences and Business Studies
No 247

University of Eastern Finland
Kuopio
2021

Grano Oy
Jyväskylä, 2021
Editor in-Chief: Markus Mättö
Editor: Anna Karttunen
Sales: University of Eastern Finland Library
ISBN: 978-952-61-3756-8 (print)
ISBN: 978-952-61-3757-5 (PDF)
ISSNL: 1798-5749
ISSN: 1798-5749
ISSN: 1798-5757 (PDF)

Author’s address: Faculty of Social Sciences and Business Studies
University of Eastern Finland
KUOPIO
FINLAND

Doctoral programme: Welfare, Health and Management (WELMA)

Supervisors: Professor Vilma Hänninen, DSocSci
Department of Social Sciences
Faculty of Social Sciences and Business Studies
University of Eastern Finland
KUOPIO
FINLAND

Docent Mari Kangasniemi, PhD
Department of Nursing Science
Faculty of Medicine
University of Turku
TURKU
FINLAND

Docent Markku Oksanen, DSocSci
Department of Social Sciences
Faculty of Social Sciences and Business Studies
University of Eastern Finland
KUOPIO
FINLAND

Pre-examiners: Professor Sirpa Wrede, DSocSci
Faculty of Social Sciences
University of Helsinki
HELSINKI
FINLAND

Doctor Marit Silén, RN, PhD
Faculty of Health and Occupational Studies
Department of Health and Caring Sciences
University of Gävle
GÄVLE
SWEDEN

Opponent: Doctor Marit Silén, RN, PhD
Faculty of Health and Occupational Studies
University of Gävle
GÄVLE
SWEDEN

Saxén, Salla
Ethics in Professional Discourse. An exploration of moral uncertainty and the diversity of ethics in healthcare professions
Kuopio: Itä-Suomen yliopisto, 2021
Publications of the University of Eastern Finland
Dissertations in Social Sciences and Business Studies; 247
ISBN: 978-952-61-3756-8 (print)
ISSNL: 1798-5749
ISSN: 1798-5749
ISBN: 978-952-61-3757-5 (PDF)
ISSN: 1798-5757 (PDF)

ABSTRACT

Healthcare professionals face moral uncertainty in their work as they confront human vulnerability in a variety of situations between life and death. This multiprofessional analysis aims to deepen the understanding of the differences between professional cultures in terms of ethics and reflect upon the professional diversity of ethical discourse in the healthcare context. The thesis explores the discourses of healthcare ethics in three professional realms: the professional writings of ethics in Finnish nursing and medicine as well as in the profession of clinical ethics consultants in the United States. The starting point for the interprofessional research design stems from the field of bioethics and its claim of making ethics an open and interdisciplinary area of research and argumentation. The theoretical foundation of the thesis is social constructionism together with the method of critical discourse analysis. The first substudy, based on interview data collected in the U.S., concerns the construction of professional vision in clinical ethics consultation. The second substudy examines Finnish professional texts on medical ethics and nursing ethics and makes visible the differences in the ethical worldviews of the two professional cultures. The third substudy, based on a secondary analysis of the first substudy, argues for seeing moral expertise in clinical ethics consultation as a paradox. The thesis concludes with the idea that there appears to be no interprofessionally shared language of uncertainty in the landscape of healthcare ethics. The professional cultures in this study hold considerably different conceptions of uncertainty and ethics in their professional discourses. Finally, organizational structures for supporting ethical dialogue are advocated for. These structures could be especially beneficial in Finnish healthcare where such practices do not exist yet. Ensuring that moral space is kept open through dialogue in this way also means recognizing that the existence and permanence of uncertainty concerns all professions participating in patient care in the healthcare environment.

Key words: moral uncertainty, bioethics, healthcare ethics, clinical ethics consultation, nursing ethics, medical ethics, social constructionism, critical discourse analysis, dialogue

Saxén, Salla
Etiikka ammatillisessa diskurssissa. Moraalinen epävarmuus ja etiikan moninaisuus terveydenhuollon ammateissa
Kuopio: Itä-Suomen yliopisto, 2021
Publications of the University of Eastern Finland
Dissertations in Social Sciences and Business Studies; 247
ISBN: 978-952-61-3756-8 (nid.)
ISSNL: 1798-5749
ISSN: 1798-5749
ISBN: 978-952-61-3757-5 (PDF)
ISSN: 1798-5757 (PDF)

TIIVISTELMÄ

Terveydenhuollon ammattilaiset ovat työssään tekemisissä elämän ja kuoleman sekä ihmisten haavoittuvuuden ja avuntarpeen kanssa. Vaativassa ympäristössä työskentelemiseen liittyy eettisiä kysymyksiä, jotka monimutkaisuudessaan herättävät ajoittain myös moraalista epävarmuutta yli ammattirajojen. Väitöskirjani tutkii terveydenhuollon etiikan monimuotoisuutta diskurssianalyyttisestä näkökulmasta kolmessa eri ammattiryhmässä ja aineistossa: suomalaisten sairaanhoitajien ja lääkärien ammattieettisissä teksteissä sekä yhdysvaltalaisten sairaalaeetikoiden haastatteluissa. Tutkimusaineiston tarkoituksena on syventää ymmärrystä eettisen ajattelun eroavaisuuksista tutkittujen ammattikuntien välillä sekä pohtia ja tehdä näkyväksi terveydenhuollon etiikan moninaisuutta. Tutkimusasetelma nojaa bioetiikkaan ja sen moniarvoisuutta ja moniäänisyyttä korostavaan näkökulmaan terveydenhuollon etiikan kentällä. Tutkimuksen teoreettinen lähtökohta on sosiaalinen konstruktionismi, ja tutkimusmenetelmänä on kriittinen diskurssianalyysi. Ensimmäinen osatutkimus käsittelee yhdysvaltalaisten sairaalaeetikoiden ammatillisen roolin ja tässä roolissa tapahtuvan niin sanotun ammatillisen näkemyksen (professional vision) diskursiivista rakentumista. Toinen osatutkimus tarkastelee suomalaisten hoitajien ja lääkäreiden ammattieettisten tekstien diskursseja. Kolmas osatutkimus perustuu välillisesti ensimmäiseen osatutkimukseen ja ottaa kantaa sairaalaeetikoiden moraalisen asiantuntemuksen luonteeseen argumentoiden sen olevan luonteeltaan paradoksaalista. Väitöskirjatutkimus tiivistyy havaintoon, etteivät terveydenhuollon ammatit näytä jakavan selkeää yhteistä käsitystä terveydenhuollon moraalisesta epävarmuudesta eikä ammattilaisilla vaikuta olevan ammatteja ylittävää, yhteistä kieltä kuvaamaan ja käsittelemään tätä työhön kietoutuvaa herkkää teemaa. Lopuksi esitetään näkemys eettistä keskustelua tukevien ja ammattien välistä diskurssia rakentavien uudenlaisten sairaalakäytäntöjen perustamisen puolesta. Kliinisen bioetiikan alalla muissa maissa kehitetyillä käytännöillä ja rakenteilla on potentiaalia avata uudenlaista, ammattien välisiä siltoja rakentavaa keskustelukulttuuria myös suomalaisessa terveydenhuollossa. Tämä on tärkeää, jotta tunnistettaisiin konkreettisemmin eettisen epävarmuuden olemassaolo ja sen jatkuva läsnäolo terveydenhuollossa teemana, joka koskettaa ja yhdistää kaikkia potilaan hoitoon osallistuvia terveydenhuollon ammattilaisia.

Asiasanat: moraalinen epävarmuus, bioetiikka, terveydenhuollon etiikka, sairaalaeetikot, hoitajan etiikka, lääkärin etiikka, sosiaalinen konstruktionismi, kriittinen diskurssianalyysi, dialogi

For Heikki

I’m thinking about the aurora borealis. You can’t tell if it really does exist
or if it just looks like existing. All things are so very uncertain,
and that’s exactly what makes me feel reassured.

Too-Ticky in *Moominland Midwinter*
Tove Jansson 1957

Acknowledgements

Writing these final words, I am joyful and relieved to find myself having come through a long process of academic growth that now appears almost impossible to put into words. Both the blessings and the pitfalls along the way have taught me a great deal, giving continuous lessons of resilience, motivation, and self-management. One thing is certain, though: I would not have been able to reach this point without the help and support of others. It is now time to express my deepest gratitude for those without whom I would not have finished, or in some cases even started, this thesis.

I am grateful for my thesis supervisor, Professor Vilma Hänninen, who welcomed me to the University of Eastern Finland in 2013 and harbored my growth as a researcher with her wisdom and guidance ever since. I have wandered around and about in the world of bioethics during these years of doctoral education, but dialogues with Professor Hänninen have always taken me back to my home discipline, social psychology. This has helped me tremendously to find clarity in my work and to focus on the methodology and scientific worldview that are the very basis of this thesis.

I want to thank Docent Mari Kangasniemi, the second supervisor to come into the process in 2014, for her incredible patience in asking me the right questions that have repeatedly led me back to my own thoughts, as strange as that sounds. It is easy to become lost, confused and overwhelmed by the many demands and potential perspectives available in scientific research. I am indebted to Docent Kangasniemi's helping wisdom in guiding me back to my focus.

I am also thankful for Docent Markku Oksanen for having joined the supervision constellation of this thesis in 2017 and sharing a mutual passion for bioethics discussions. I am thankful for his attempt to enlighten me about philosophy (regardless of whether this effort has proven successful on my part in the end). It is obvious that I am not in my academic comfort zone in philosophy, but I am curious and willing to learn.

I am also thankful for Professor and Dean Juho Saari for first having helped me to get my foot into doctoral studies and the WELMA doctoral program at the University of Eastern Finland. An initial mutual project and funding applied for in 2013 did not receive its wings, but that application put me on the path to my doctoral studies, and I am grateful for all the subsequent opportunities that opened up for me. I also want to thank my thesis pre-examiners, Professor Sirpa Wrede and Dr. Marit Silén, for their helpful feedback at the end of the process. You offered valuable insights and perspectives that I had been oblivious to.

Having been trained in social psychology, I would not have attained a deep understanding in the field of bioethics without the incredible luck of having been accepted to the Harvard Medical School Bioethics Fellowship in the fall of 2014, a year-long intensive study program delving into bioethics topics and discussions. I am grateful for Executive Director of the Center for Bioethics Christine Mitchell for having thought of me as having the potential to apply to this program and for further mentoring me along the way. I am also incredibly indebted to the primary teacher of the Fellowship, Professor Mildred Z. Solomon (or Millie), for encouraging me with my writing throughout the program. Professor Solomon's encouragement encouragement helped me to establish my academic self-esteem when I was only in the caterpillar stage of forming my researcher identity. Having been encouraged at that point has made all the difference, because it has given me the courage to form my own views and arguments ever since. I am also thankful to all the Fellows of the year 2014–2015 for the dialogues and mutual encouragement that I was so fortunate to be part of.

I also want to thank all the people who have been part of the initiative to establish clinical bioethics structures at Tampere University Hospital during the years 2016–2019. I am especially grateful for Professor and Dean Tapio Visakorpi for welcoming a bioethics perspective into his research team and opening up numerous possibilities for a young scholar, from establishing a mutual research project all the way to proposing me and bioethicist Heikki Saxén for the annual ethics award that we were later nominated to receive by the regional ethics committee in 2019. I also want to thank Dr. Heikki Oksa and Bishop Juha Pihkala from the ethics committee for welcoming us to speak there and being open minded toward our work over the years. Additionally, I am grateful to Dr. Tanja Saarela and Dr. Satu Lehtinen for organizing training in moral case deliberation in 2019 and allowing me to participate in this training, led by the incredibly inspirational teacher Bert Molewijk.

I have also been fortunate to be able to visit the Hastings Center twice as a visiting scholar during these years, first in 2015 and later in 2019. I am grateful for the visionary and thought-provoking scholars at the Hastings Center who had conversations with me during my stay and encouraged me to continue the work on the vision of establishing clinical bioethics practices in Finland.

I have been blessed to receive generous funding during the years of writing this thesis from the Finnish Concordia Fund, Emil Aaltonen Foundation, the Finnish Cancer Foundation, and the University of Eastern Finland. I am grateful for every euro that has allowed me to focus on my research. I can only hope that my work further benefits the Finnish society in a way that makes this support worth it.

I want to thank my parents, Auli and Matti, for being patient with my perennial educational endeavors and supporting me along the way. My parents have always encouraged me to choose my own path, never forcing me to fit into anybody else's ideals or demands. This freedom has allowed me to take detours and experiment in free and creative ways, and I am grateful for having received such a safe environment for learning and growing. I am also thankful for my brother, Jouni, for always believing in me and supporting me from day one of my life.

Finally, I thank my spouse, Heikki, my bioethics colleague and lasting inspiration, for enduring this academic adventure with me. Heikki has witnessed all the ups and downs all the way from supporting me when I nervously took my university entrance exam for social psychology to this day when I am finally finishing this thesis. Words cannot express the depth of the journey we have walked together, and I can only hope for many more years and adventures in the future. You are the light of my life.

Table of contents

List of figures

ABBREVIATIONS

MCD	Moral case deliberation
CEC	Clinical ethics consultation
CECs	Clinical ethics consultants
CDA	Critical discourse analysis

1 Introduction

Imagine you are an intensive care pediatrician faced with making the decision about whether or not a three-year-old child dependent on ventilator treatment still has a hope of survival. Let's call the child Anna.

You are deciding whether Anna's ventilator's plug should be pulled or the treatment continued. You are aware that little Anna's survival seems highly unlikely, but sometimes miracles happen. They have happened in this intensive care unit before, and the staff frequently reminisces about these stories of cured children. Then again, needless suffering caused by too many medical interventions happens much more often. Those stories are less often recalled.

Imagine that the situation is made even more complicated by Anna's parents, whose views conflict with one another. The mother is begging you to end Anna's ventilator treatment: She says that it brings unnecessary suffering. Anna's father persists in carrying on: He wants to wait and see what happens the next day. You do not know for sure if one of the parents, or both, or even yourself, are being overly optimistic or pessimistic. You are worried not only about Anna but also about the wellbeing of her conflicted parents. The only thing certain about the situation with little Anna is that, from your viewpoint, there is uncertainty about the right thing to do.

You are at the core of what this thesis is all about by imagining yourself encountering a situation like this. You are positioning yourself within the struggle, the moral conflict, the difficulty of knowing what is good and right in unfortunate circumstances—namely, the murky waters of clinical moral uncertainty.

1.1 Study setting: Moral uncertainty and the tensions of healthcare ethics

This thesis is about ethics in the healthcare environment. I study different professional viewpoints on ethics to bring the complexity of healthcare ethics to light. However, this thesis is first and foremost about being curious regarding the many ways that healthcare professionals define and manage their professional role in the face of moral uncertainty. What I take for granted—as a starting point—is that an underlying potential for uncertainty exists in much of healthcare work.

The moral uncertainty of clinical practice spreads in many directions and is faced by all healthcare professions. Defined roughly, moral uncertainty means uncertainty about **the right thing to do** in a situation when there is more than one potential option available (see, for example, Bykvist 2017). The uncertainty is often about several things at once, such as deciding whose values count, and why, in a complex situation. This moral uncertainty in clinical care about choosing the right values is also mixed with uncertainty about outcomes, as clinicians cannot be entirely sure what will happen after choosing a certain path. Medicine is not a science of exact outcomes in the sense that a certain treatment would always lead to the same results. A treatment that is successful for one patient may be inconsequential or even detrimental to another.

Whatever is decided must be based on a solid ethical foundation when all options are uncertain and decisions must nevertheless be made. However, decisions based on healthcare ethics are not made in academic ivory towers: Vexing questions are deeply confronted by both professionals and patients, because the ethical choices of clinical care must be made regardless of their complex nature and often at a fast tempo. On top of dealing with complex ethical questions, the social side of such decision making may cause additional complexities and value conflicts between stakeholders. Dealing with topics like these is at the heart of bioethics, the umbrella field to which this thesis attempts to make its own small contribution.

Deep down, moral uncertainty in healthcare stems from the fact that **healthcare exists because of patients.** The patient is the initial agent whose presence brings healthcare—its professions, institutions, practices and ethical standards—into being. This ethical duty first and foremost toward the patient is clearly articulated in the Finnish Healthcare Professionals Act: “The aim of the professional activities of healthcare professionals is to promote and maintain health, to prevent illness, to cure those who are ill and to alleviate their suffering” (Finlex 559/1994[1]).

The patient causes healthcare professionals to experience ethical uncertainties for many reasons, due as much to the patient’s illness as to her lifestyle, worldview, values and even family dynamics also being entangled with her care, potentially making it more complicated. Thus, every patient is unique, at least in some ways. No matter how deeply healthcare institutions and professions are technocratically regulated and managed or how efficient medical technology becomes, the patient and her lifeworld cannot be fully anticipated, technically controlled or disciplined by authoritative instructions. This is because, in the end, **the patient is a person** and must, just like the rest of us, be appreciated and encountered as such: with her unique personality, values, and personal history in mind.

Healthcare cannot—and naturally, should not—escape the patient, but moral uncertainty has the potential to surface from any angle you examine it through the prism of healthcare. I do not claim that healthcare professionals would face explicit uncertainty every single day in their work. However, I start with the premise that if one looks carefully enough, one will see that the seeds for uncertainty are there—even if a conflict or dilemma only bubbles up to the surface occasionally.

Clinical moral uncertainty can be thought of as something like a steady current: It is unmistakably there, but it is also something that is so embedded in the surroundings that one may become occasionally blind to it in the clinics’ daily hustle and bustle—as if it was hiding in plain sight.

1.2 Research design and research questions

The research for this thesis started with my curiosity about healthcare ethics, which was first impelled by hearing about the field of bioethics. I was fascinated by its claim to be the subject of multidisciplinary scholarship—including

---

[1] Direct link to the English translation of the law: https://www.finlex.fi/fi/laki/kaannokset/1994/en19940559_20110312.pdf

by nonphysicians like me—in which people were pondering upon the very fundamental value questions of medicine. This bioethical beginning prompted my first interest in the topic, and it has followed throughout the thesis ever since.

It seemed clear from the start that having to make difficult decisions—such as forgoing life-sustaining treatment—has the potential to raise uncertainty in any professional, a human being, standing at the bedside. After all, these were the very questions of life and death whose answers were not simply found in technical guidebooks; they were decisions touching upon levels of thinking that are not simply guided by cold rationality. Rather, they manifested the kinds of issues that delve into much more personal, spiritual and value-laden levels of thinking. My curiosity as a social scientist found its focus on this uncertainty, sparked by wondering how professionals dealt with it. I wanted to discover what kinds of professional constructions of ethics they had to guide them when confronting and solving such situations. After all, being present in ethically confusing and emotionally heart-wrenching situations was their job, so it seemed obvious that professionals would have developed some kind of knowledge, method and practical wisdom over time for such situations.

Ethical assessment extends to all aspects of life, but it seemed clear from the start that perhaps nowhere else were they as important as in healthcare, an environment in which people are vulnerable, their lives depending—quite literally—on the expertise and good intentions of professionals. The particular weight put on ethical dimensions in the healthcare environment stems not, however, merely from those individuals' vulnerability but also from the overall complexity of the situations. Ethical quandaries can be no less than questions about life and death, such as end-of-life decisions (see, for example, Berlinger, Jennings & Wolf 2013) or about prioritizing scarce healthcare resources (see, for example, Brock 2007; Daniels & Sabin 2008). After all, **doing something good** is a moral deed; therefore, practicing healthcare is never only a technical performance but is also an action requiring ethical sensitivity and thorough assessment and evaluation. In other words, in healthcare, "clinical care and ethical duties run smoothly together" (Jonsen, Siegler & Winslade 2010, 1). I refer in this thesis to this incredibly vast scale of topics and discussions by the general term **healthcare ethics**. This is because I do not want to frame these questions as concerning only physicians by calling them “medical ethics” or only bioethicists by calling them “bioethics.” The term healthcare ethics, thus, meets in the middle, bringing different professional views under the same conceptual roof. However, I will further explain in more detail how **bioethics** in particular sparked my curiosity and research design in a way that led to studying different professions side by side in the first place.

For a social scientist interested in the social construction of discourse, **ethics** as a concept appeared as something so abstract, so hidden between the lines in everyday life that it seemed to offer boundless opportunities for studies that could grasp constructions lying beneath the surface. “Ethics” is, after all, a difficult word, because it can easily be used not only in the search for the good but also in vague and even misleading ways. It is as much a philosophical term as it is a word characterizing professional guidelines—and yet it is so much more than this. It is also a socially powerful word that can be used in ceremonial orations to emphasize noble goals, while actual decisions may, in fact, be made with the intention of gaining economic, legal or other forms of social power for an institution, group, or individual. Thus, when viewed as a social concept, healthcare ethics has a confusing—and therefore an endlessly fascinating—array of meanings. However, it was clear to me from the start that I would not have very much to offer to healthcare ethics in a philosophical sense. However, I sensed that not all had been written about the social construction of the world of healthcare ethics, especially its forms of dealing with uncertainty. This interest led me early on to discover the research tradition of **descriptive ethics**, the empirical rather than normative study of moral thinking and action. This thesis and its substudies further found their place under this umbrella of ethical inquiry.

The initial questions prompting this study’s research were, **how do healthcare professionals make sense of the abstraction of what ethics means to them in their professional role in which dealing with moral uncertainty is a given? And how do these constructions differ between the studied professions?** After all, I started with the idea that all professions would face some kind of moral uncertainty. This curiosity was further fueled by the very idea stemming from bioethics to bring the perspectives “around the same table" and reflect upon them. I was also aware from the beginning that this kind of an interdisciplinary bioethics approach was not very well known or commonly practiced in the Finnish healthcare setting. Needless to say, it seemed obvious, as an inquisitive young Finnish scholar, to ask why should it not be—is there something in Finnish healthcare ethics that resists bioethics? Is bioethics just not fit for the Finnish context? Or is it just something we have yet to discover? I hoped understanding healthcare ethics discourse both in clinical bioethics in the U.S. and Finnish professions could offer some insight into these questions.

I start this thesis from the social constructionist theoretical beginning that any social reality consists of social construction—discourse—that shapes the common ways of talking about and understanding the topic. Healthcare ethics is no exception to this, and my exploration begins with a curiosity about the constructions that are circulated in relation to healthcare ethics for different professionals, in both the American bioethics discourse and the Finnish healthcare professionals' discourse. My primary attempt in exploring the ethics discourse of the studied professions is to **understand differences and to reflect upon them**, because my view is that **it is only by understanding differences that we can become aware of the things we take for granted**. After all, the discourse that surrounds us is typically invisible to us, just as water is to a fish. For the fish to understand the water it swims in, it is important that it become aware of both the water and what is beyond it. Making differences explicit is a way to explore discourse and is aligned with the method of critical discourse analysis (CDA) used. Analyzing discourse means making the familiar strange and making the implicit (the "water") explicit and open for reflection. What better way to do this than to hold different traditions side by side and reflect upon them? For this reason, I not only contrast data from two very different cultures—Finland and the United States—in my research, but I also study different professions side by side. Just as returning home from a trip to a faraway country can make one suddenly more aware of one's own culture and surroundings, taking on different realities for side by side analysis makes the differences more visible than how they would appear without the contrast. My point of entry to the data, the "home base" from which I start and return to, is the bioethics perspective of viewing healthcare ethics as a pluralistic collection of voices that are all welcomed in one thesis under one roof, so to speak.

In summary, in this thesis I explore **how ethics is understood in medicine, nursing and clinical ethics consultation** by starting from the basic tenet that while discourse varies, dealing with moral uncertainty is confronted by all of these professions in the healthcare context. My inquiries begin with the following research questions:

1. How do the different studied healthcare professions think about ethics?
2. What kind of worldview do they construct? What do they see through that lens when they talk and write about ethics?
3. What is implicated as important and meaningful for the different professional perspectives—and what, in turn, is not?

I also take different kinds of angles to the questions in the separate substudies. I am curious about themes such as professional vision, professional identity, and moral expertise. These themes are all bound together by the effort to understand and reflect upon the different kinds of healthcare ethics discourses. In the end, I will return to the bioethical claim that first launched me on this research journey and discuss whether I view bioethics as offering something new to the Finnish healthcare ethics discourse.

My intention throughout this thesis has been to retain an open mind for understanding difference and to cultivate a sense of open-ended diversity when facing the ethical landscape of healthcare, while I simultaneously encourage the readers to reflect on their own ethics worldview. I put the same grand vision in the famous words of T. S. Eliot, who said, “We shall not cease from exploration, and the end of all our exploring will be to arrive where we started, and know the place for the first time.”

1.3 Structure of the thesis

The thesis summary develops with the following structure. Chapter 2 introduces bioethics, the field of ethical inquiry providing the historical and intellectual backdrop for my research. Chapter 3 addresses social constructionism, the social scientific theory that lays the theoretical foundation for my empirical studies. Chapter 4 brings together these two defining features of the framework—social constructionist research and bioethics—to further focus my research setting and research questions. Chapter 5 introduces the methodological choices made in the two empirical substudies. Chapter 6 presents the results and insights of all three substudies. I circle back at the end to what the research journey has taught me about the value of bioethics and what I think, ultimately, about its potential for Finnish healthcare. Therefore, chapter 7, the final chapter, consists of the general discussion of the thesis in which I gather my insights to make the argument that healthcare ethics is best when its met in dialogue.

2 Bioethics: exploring ethics in multiprofessional healthcare

> "No other field of study reflects the contemporary age more faithfully than bioethics, a systematic study of moral conduct in life sciences and medicine. Medicine and the life sciences are to our period in history what religion and salvation were in medieval times. They are the focus of enormous societal resources and the central concerns of most modern people."
> Drane 1994, ix

I introduce bioethics as a discipline in this chapter, because bioethics creates an important backdrop for all my studies. In a way, I have come to ask all the research questions that I ask **because of bioethics,** because the discipline provides an interesting point of departure for asking questions about ethics in the healthcare context. I first introduce the field of bioethics in general and its historical origins. I then examine the practical implications of bioethics to introduce the many clinical applications that bioethics has inspired people to develop around the globe, especially focusing on the bioethics practices in Finland and other Nordic countries. I address the academic and intellectual roots of bioethics—the field of moral philosophy and its theories of normative ethics—at the end of the chapter to provide the theoretical background for the substudies of this thesis.

2.1 Foundations of the field

The term bioethics comprises the Greek words **bios**—meaning life—and **ethos**—meaning habits, behavior or values. An academic dispute continues regarding whether or not bioethics counts as a scientific discipline, but I regard bioethics in this thesis as a discipline that is generally defined as the systematic study of the moral dimensions in the life sciences and healthcare realm, such as medicine and other biomedical sciences, including biomedical engineering, genetic epidemiology, and more. (See, for example, Jonsen 1998; for argumentation about bioethics as a discipline, see also Saxén 2017.) Dickenson (2012, 2) more practically sums up bioethicists' work as efforts "to make sure that the onward march of science doesn't trample down vulnerable populations, to prevent harms from outweighing benefits, to ask whose interests prevail and to ask questions about whether justice is being served by new scientific developments."

Bioethics thematically overlaps with medical ethics, yet bioethics should be conceptually differentiated from medical ethics. Bioethics represent a cultural breakage, a change of ethos, in comparison to the long history of medical ethics that came before it. Historian Albert Jonsen (2000) divides the developments of moral thinking in medicine into three phases: **decorum**, **deontology**, and **politic ethics**. Decorum refers to virtues and etiquette and puts weight on the physician's character as a basis for moral conduct in medicine. This ethic is identified as being most prominent in Ancient medicine and the classical world. Deontology, developing especially in Medieval medicine, shifted the focus from the character of the healer toward shared rules and principles. Finally, politic ethics, the latest development in medical ethics, concerns the role of medicine in the context of the larger society and introduces questions of justice. The justice theme rarely appears in the early medicine of antiquity; Jonsen depicts it as starting to emerge with the professionalization of medicine during the Renaissance era. These phases, expanding from the classical era to the first half of the 20th century, represent what Jonsen calls the "long tradition" of medical ethics. (Ibid.)

Traditional medical ethics centers more practically around the physician–patient relationship and holds profession-based guidelines and the physician's character to a high standard (such as the professional code of conduct). Bioethics, too, delves into physicians' dilemmas and the physician–patient relationship alongside traditional medical ethics, but in addition to this, bioethics is also concerned with external issues important to patients and society that go beyond the medical profession's realm (Dzur 2008, 208). Emerging in the 1970s while connecting to the latest era of the long tradition—politic ethics—bioethics introduced interdisciplinary scholarship, a new characteristic unforeseen in the medical ethics tradition. As a result of this cultural shift, bioethics welcomed people from outside of medicine into deliberations in councils, committees and commissions that, for the first time in history, included a variety of laypersons, professionals and interdisciplinary scholars (Jonsen 2000, 118–119). Bioethics, thus, takes the questions of medical ethics into greater interdisciplinary, societal and governmental dimensions. This shift of focus from inside the medical profession to outside of it is characterized in practical terms by bioethicists themselves: Many have, for example, theological or philosophical rather than medical training (Dzur 2008, 209).

Dzur (2008, 209) claims that, whereas traditional medical ethics is a form of self-control and self-critique for physicians, bioethics, instead, approaches the same ethical questions with a degree of public critique and control. This newer tradition of external versus internal control in the medical profession originally developed out of the concerns of ethicists who worried that "the old tradition of medical ethics was too frail to meet the ethical challenges posed by the new science and medicine" (Jonsen 1998, 3). Unlike the long tradition, the bioethics perspective decreases the weight put on profession-based codes or physicians' character and focuses instead on interdisciplinary, topic-based discussions. This means experts from different fields—physicians, nurses, philosophers, theologians, and social scientists, for instance—gather to discuss topics such as defining when treatment is futile, the different methods of prioritization, healthcare justice, or forgoing life-support, for example.

The cultural shift from traditional medical ethics—emphasizing physicians' character, behavior, solidarity, and educated competence—to the new bioethics reflected the greater societal changes of the post-World War II era in the Western world and more widely. Medical science advanced and medical interventions became more technical than before: Impersonal machines suddenly intervened in what had been thought of as the sacred doctor–patient relationship. Traditional duties such as the physician's traditional command to "do no harm" were challenged by the mere difficulty of telling what precisely the harm is: The question suddenly became whether sustaining life through a medical machine was, in fact, a benefit or a harm. (Jonsen 1998, 11.)

Bioethics as a field has both a practical and a scientific function: It is an effort not only to **study and understand** but also to **influence** the social life and society around us. Differing from more traditional academic disciplines—such as philosophy, history, or anthropology—the field of bioethics is unusual because of its increasing acceptance within the everyday practice of healthcare institutions, especially in North America, as well as its social prominence and media appeal (Churchill 1999, 254).

Bioethics consequently operates in the arenas of **both knowledge and politics**. These different purposes in the field are reflected in the vast array of roles that bioethicists take. Academic bioethicists analyze ideas, theories and concepts relevant to healthcare and the life sciences. Clinical bioethicists facilitate when moral conflicts arise in hospitals, discuss values and moral dilemmas with healthcare professionals and sit in ethics committees to participate in making decisions on topics such as hospital policy. In addition to these, bioethicists may provide legal advice, contribute to political healthcare decision making, serve as experts in institutional review boards (IRBs) or consult on topics such as risk management.

2.2 Historical overview

The birth of bioethics as a discipline is rooted in major coincidental social and biomedical developments occurring in the Western world, especially in the field's central birthplace, the United States. Biomedicine has made advances over the last five decades that would have been unbelievable and even unforeseeable at the beginning of the 20th century. Innovations such as pacemakers, organ transplantation, dialysis, ventilators, and in vitro fertilization—"the test tube babies"—were introduced in the 1960s and 1970s, to name some. Along with the new emerging technology, bioethics started to develop as a discipline when questions about the moral dimensions of the new, incredible medical possibilities started to seem inevitable. Bioethics became an interdisciplinary field right from the beginning, even though philosophy and theology especially played foundational roles in its creation (Jonsen 1988, 34–58, 65–84).

Callahan (2012, xv) summarizes bioethics as having a number of cultural roots ranging from an ambivalence about technology to the upheavals in the 60s that included suspicion of any established institutions. Bioethics developed in a time of societal democratization that involved harsh criticism of past authorities, including those in the medical profession. The 1960s and 70s introduced the "hippie culture" as well as the civil rights movement in the U.S. and a push for women's rights throughout the Western democracies. And not to forget the obvious, the close history of that era was overshadowed by World War I, from the inhumane horrors and human experimentation of Nazi concentration camps to the atomic bombs of Nagasaki and Hiroshima. Both the moral use of technology and the moral righteousness of the medical profession were under heavy criticism by the public after World War II. The United Nations General Assembly signed the Universal Declaration of Human Rights[2] for the first time in 1948, signifying the beginning of a new era of moral regulation and public concern about governments and authorities. The Nuremberg Code was also established in its final form in the same year, declaring research subjects' right to informed consent (see Bulger 2007). The Nuremberg code was an international document, but it did not initially carry the force of law in most places and was, therefore, blatantly violated on many occasions (Bulger 2007, 81). The time may not have been ripe for the ethos of the codes right after they were published, yet the emerging field of bioethics would build in the following decades on the ethos and heritage that these documents have come to signify—open society, individual rights, and freedom of thought and religion.

The skepticism in the zeitgeist, in turn, provoked questions about who should be the legitimate authority to make ethically complex decisions, such as deciding whether a critically ill patient's life support should be terminated. Physicians would have unquestionably made such decisions in earlier times, but since the physician's authority was contested, questions about who was to be the new, legitimate decision maker arose. The undeniable question "who should decide?" was the central content of bioethical conversations during the 1960s and 1970s (Callahan 2005).

The context of clinical care and healthcare are now a major field of influence for today's bioethicists, but Rothman (1991, 10) writes the story

---

[2] See https://www.un.org/en/universal-declaration-human-rights/.

of bioethics as having begun in the laboratory rather than in the examining room. Whistleblowers made exposés in the 1960s about the practices in human experimentation, and stark conflicts of interest were revealed of instances of patients' well-being being sacrificed because of researchers' ambitions. Scandals unsurprisingly followed these accounts. The result was the formation of an entirely new system of governance for human experimentation, introducing formal structures of oversight (institutional review boards) and putting new emphasis on the role of the research subjects themselves through the then-emerging principle of informed consent (Ibid., 70–100).

The same dynamics later spread to clinical care or, in Rothman's (1991) terms, to the "bedside." The latter half of the 20th century saw bioethics spreading fast in North American healthcare institutions as clinical ethics committees were being established, and a novel job title emerged in hospital wards: the clinical bioethicist. Conclusions about the vast spread and establishment of the field can be made due to the fact that the Joint Commission on the Accreditation Manual for Hospitals concluded in 1992 that in order to gain accreditation, U.S. hospitals were from then on required to have a "mechanism(s) for the consideration of ethical issues in the care of patients and to provide education to caregivers and patients on ethical issues in health care" (see Heitman 1995, 412–413; original source Joint Commission 1992, 156).

It is clear that bioethics emerged as a response to a changing time. The emancipated attitudes of the 1960s and 70s also brought a critique against **paternalism** as an attitude in medicine. Physicians' ethics and laypeople's conceptions of ethical behavior had simply grown too far apart from each other due to the changing attitudes of the times—Veatch (2005, 208) calls this expanding moral distance "the dissonance between physician ethics and other ethics." Autonomy, meaning patients' right to make decisions for themselves when considering their treatment, emerged in medical language during the decades following the emergence of bioethics in the 60s. The patient's autonomy was then (and only then) established as a basic ethical principle for medical care in many Western societies. Today, autonomy is so taken for granted that it is hard to even imagine that before the critical challenge to physicians' ethics in the 1950s, "physicians intentionally withheld grave diagnoses from patients; they did research on them without informing them; they sterilized some patients whom they thought were not worthy of being parents; they routinely kept critically and terminally ill patients alive against the wishes of patients; they refused to perform sterilizations, abortions, and provide contraceptives if they thought patients shouldn't have them; they allocated scarce resources in controversial and nondemocratic ways" (ibid). So radical was the push from bioethicists and from society that paternalism eventually had to give way to a demand for the right of patients to decide for themselves while gaining adequate and truthful information about their medical conditions from their doctors. After such a profound change, it is hard to remember that before the establishment of the principles of autonomy and informed consent, "physicians' authority over their patients was complete and absolute" (Sher & Kozlowska 2018, 35).

It was, thus, in the historical, social and political context of the post-World War II era that bioethics emerged, "beginning as an amorphous expression of concern about the untoward effects of advances in biomedical science and gradually forming into a coherent discourse and discipline" (Jonsen 1998, xiii). Bioethics grew out of the Anglo-Saxon cultural ethos that emphasizes individual rights and interests with the central value of institutions bearing responsibility to the individuals rather than the other way round—in other words, "the moral triumph and vindication of an open society" (Jennings and Moreno 2011, 269). Bioethics has participated in the societal efforts to create new kinds of social and governmental structures since the field's emergence to keep conversations about ethics vivid in healthcare arenas, from practices such as institutional review boards to clinical ethics committees. Having first started as a critique of the establishment and authority, bioethics itself grew to render a new era of authorities and establishments into being.

2.3 Bioethics in Finland and abroad

The ways and measures in which bioethics practices—such as ethics consultation or ethics committees—have been absorbed by the social, institutional and governmental agendas in different countries around the globe vary greatly. Having first originated as a field of inquiry in the United States and reflecting a primarily Anglo-American cultural ethos, bioethics has later increasingly spread to many countries around the globe, from the developed West all the way to Eastern countries such as China and India (for global bioethics, see Myser 2011).

I will shortly introduce in this chapter some of the ways in which bioethics has been applied to practices in **clinical** contexts, or more informally, "at the bedside." Still a fairly uncommon practice in European hospitals, in North America—United States and Canada—clinical ethicists are routinely hired or designated to assist staff and patients to deal with the ethical issues emerging in healthcare (see, for example, Coughlin & Watts 1993; Greenberg et al. 2013; Fox 2007). However, the term ethics consultation, also known as ethics support, can refer to a wide scale of different practices, from the work of an individual or a group of consulting ethicists to the deliberations of a large, multidisciplinary clinical ethics committee (see Fox et al. 2015, 3–5 about the different models for ethics consultation).

Ethics consultations have many goals for the North American hospitals where they are practiced. The overall aim of their practice can be defined as "to improve the quality of health care through the identification, analysis, and resolution of ethical questions or concerns" (Fox et al. 2015, vi). Effective ethics consultations are seen to 1) promote practices consistent with high ethical standards, 2) foster consensus and resolve conflicts in a respectful atmosphere, 3) honor participant's authority and values in the decision-making process, and 4) educate participants to handle present and future ethical concerns (ibid.). European countries have also slowly become interested in ethics consultation: For example, Fournier et al. (2009) recorded over ten years ago that consultation services were being implemented in certain hospitals in France, Norway, Germany, the United Kingdom, and Italy. Eleven years later, it is likely that clinical ethics practices have become even more common outside of North America. Time will tell whether the coronavirus crisis—manifesting at the time of writing this in the spring of 2020—will have the potential to change clinical ethics practices in healthcare institutions around the globe in unprecedented ways.

Next, to provide context, I briefly examine some of the practices that are carried out in the European context as well as the current situation in Finland in relation to this topic. Bioethics has spread to many different spheres and contexts among the Western developed and democratic societies, yet Finland is a curious exception, because there are no established, influential structures existing for practical applications of bioethics in clinical settings. Bioethics has become slightly more common in Finland as an academic topic, with people from different backgrounds and disciplines working on bioethical themes (see, for example, Häyry 2010; Launis & Räikkä 2008). However, the marginality of the field is reflected by the fact that there is no academic degree (or study program) available in Finnish universities that would lead to the specific skillset of a 'bioethicist.'

Despite the fact that some academic discussions on bioethics endure in Finland, the clinical domain is strangely silent: neither clinical tradition nor legislative mandate for having interdisciplinary ethical discussions in **clinical environments** exists.[3] Most hospital districts, however, have ethics committees that discuss ethics at the level of principle (Louhiala et al. 2012, 83). These hospital committees rarely, if ever, pick topics with reference to the uncertainties purporting in the grassroots levels of clinical care. Additionally, a nation-wide ethics committee under the Ministry of Social Affairs and Health discusses "general principles in ethical issues in the field of social welfare and healthcare and concerning the status of patients and clients as well as to publish recommendations on them" (online resource, see ETENE).

One indication of the need for an ethics consultation service in the Finnish clinical setting is the establishment of a web-based physician's ethics forum (Louhiala et al. 2012). However, the forum is composed solely of professionals from medical subspecialties and is available for use only by physicians. Based on the intradisciplinary formation of the forum and the fact that the forum responds to cases within the duration of a whole month, the observation

---

[3] It should be disclosed here that during the years of making the substudies for this thesis, it has been my personal professional aspiration to introduce bioethics in Finland for the clinical audience. However, while clinicians have often found the topic fascinating, the practical undertakings for establishing bioethics practices have so far not succeeded.

can be made that the physician’s forum is not actually an active service in comparison to the clinical bioethics services elsewhere. Conversations about a need to support the ethical competence of nurses exist in Finland in addition to the physicians’ forum (for example, Poikkeus 2019; Poikkeus et al. 2013). Both of these examples sustain a strong profession-based ethos of ethics in which nurses and physicians are separated from being exposed to each other’s influence, even though in the nursing research the difficulty of reaching multiprofessional dialogue is recognized as a barrier to enhancing nurses’ ethical competence (Poikkeus et al. 2013, 13).

Formal structures are yet to be established, but a new interest is emerging in Finnish healthcare regarding the practice of moral case deliberation (MCD) and other similar, structured and facilitated group discussion models (see Nikunen 2018; Peltoniemi et al. 2018). Moral case deliberation is a Dutch step-by-step method for guiding reflective, interdisciplinary and proactive case discussions on ethically complex cases with professionals, facilitated by a trained MCD-facilitator (for an introduction to the method, see Molewijk et al. 2008). However, MCD has not become an established practice so far in Finland’s clinical scene, because it is operated **without** a formal hospital structure and budget, being organized on a case-by-case basis by a handful of clinicians enthusiastic about the method. Regardless of the promising, newly developing interest in MCD, it still seems reasonable to make the claim that the Finnish healthcare system is a tough nut to crack for the influence of what could be called the “bioethics ethos”: that is, an orientation toward value pluralism, interdisciplinarity, transparent structures of documentation of clinical ethical decision making, case-by-case consultation and dialogue, and the pursuit of having an institutionally organized space for open-ended moral discussions.

Unlike Finland, other Nordic countries appear to express a genuine interest in clinical bioethics. Clinical ethics committees dealing with prospective and genuine clinical cases (hence, not solely on the level of principle) have existed in Norway since 1996, and most of the hospital trusts had a clinical ethics committee already by 2008. The Section for Medical Ethics at the University of Oslo is funded by the Ministry of Health and Care Services to support the ongoing clinical applications in terms of coordination and competence building. (Førde et al. 2008, 17.) The Norwegian model of clinical ethics operates mostly through the committee model to which the Ministry mandates the hospitals to provide. Additionally, pilots have been initiated to experiment with ethics consultation (see, for example, Pedersen et al. 2009, 461).

Academic bioethics is flourishing in Sweden at the University of Uppsala's Center for Research Ethics and Bioethics, as well as in smaller units in other universities. However, clinical ethics is not as formally structured in Swedish hospitals as it is in Norway, because there is no parallel authoritative mandate for organizing clinical ethics committees. However, some clinical ethics applications inviting multidisciplinary discussions of ethics are implemented in everyday healthcare practices, because there are research studies of ethics rounds with clinical professionals (Silén et al. 2016) and of the practice of moral case deliberation in Swedish hospitals (Rasoal 2016).

Clinical ethics committees in Denmark dealing with patient care have only lately been established for both psychiatric and somatic healthcare. However, even though clinical ethics structures are in use, no national requirement demanding hospital trusts to secure clinicians' access to ethical consultant services exists (Bruun et al. 2018). After the establishment of the first ethics committee in 2010, ethics reflection groups (ERGs) were additionally implemented to include the moral support for the reflection of moral quandaries in everyday clinical practice (Bruun et al. 2019).

This short outline of the bioethics practices in Nordic countries indicates a continuously strengthening interest in implementing bioethics in hospital clinics, from organizing formal institutional forums all the way to case reflection groups supporting healthcare professionals and patients in their clinical-ethical decision making. Toward the end of the thesis, I will make the case for why I believe Finland would gain from the implementation of bioethics practices as well, embracing the example of the neighboring countries.

However, before moving on to the social scientific theory and methodology of the studies, it is important to note that bioethics builds on moral philosophy as its backbone. Therefore, I will next address some basic ethics concepts and theories to provide further theoretical context for the thesis.

2.4 Theoretical diversity in normative ethics

Introducing the theories of moral thinking is important for this thesis, because they create understanding about the **theoretical diversity** of ethics as a wider discipline. The different traditions of normative ethics are indirectly but noticeably echoed in the **social diversity** of healthcare ethics that I have studied in this thesis. I will shortly introduce the basics of central normative ethical theories to provide the reader a theoretical background for understanding the varieties of ethical reasoning. Going through the research findings later in the thesis, a careful reader will detect tracks of deontology, consequentialism, virtue ethics or care ethics.

Normative ethics as a branch of moral philosophy is directly connected to bioethics because of its theoretical and analytical frames that are useful for addressing bioethical questions. Normative ethicists seek to identify abstract principles or a principle generalizable enough to be applied in different kinds of moral contexts. Realizing how different kinds of standards have been set by normative ethicists reveals the nuanced diversity of ethics as a discipline. Understanding this diversity brings forth the realization that—as Scottish philosopher Alasdair MacIntyre (1981 & 1988) has famously argued—there is no one "grand theory" in normative philosophy that all philosophers would or could agree on. MacIntyre claims that objectifying arguments are like masks philosophers wear to look rational, but this does not turn their ethical arguments into generally objectifiable realities. Lacking general arguments that could be shared by all philosophers, the field of ethics rather consists of traditions of thinking, such as the Aristotelian, Augustinian, Thomist or Humean thought.

Normative theories can first be distinguished into two categories. **Ethical pluralism** comprises theories in which ethicists seek to articulate several coexisting moral principles to guide moral action. **Ethical monism**, however, refers to theories that aim to determine one central, supreme ethical principle. Ethical pluralism is a very characteristic—even though disputed—approach in bioethics and is often in practice known as **principlism** (Beauchamp & Childress 2012). Principlism is a particularly practical theoretical approach for ethical decision making, because by acknowledging moral pluralism to begin with, people are able to combine different moral epistemologies that typically are thought to be in conflict with one another. Principlism focuses on the widely shared moral principles of autonomy, beneficence, nonmaleficence, and justice as its guiding principles for ethical analysis. (Ibid.; see also Bulger 2007.)

Ethical monism—theories written with the intention of identifying one principle to guide moral action—can be classified into two great traditions of moral philosophy: deontology and consequentialism (also known as utilitarianism). **Deontological theories** invoke the argument that certain deeds are ethical because of **principle** and the **inherent value** of the actions. Therefore, a healthcare professional who approaches a professional ethical question with a deontological viewpoint does not reflect on the value considerations of individuals, such as what values may count and why in making the decision; rather, she looks at the situation in the light of the principles that have been determined to guide her professional action. Deontological thinking is therefore inherently **rule-based**[4]. (See, for example, Darwall 2003.)

Consequentialist theories or utilitarianism, though, puts weight on the ethical value of actions in relation to the **consequences** of the actions. A professional who chooses to approach an ethical dilemma with the utilitarian frame is not looking for principles; instead, she is asking, "Are people benefitting from this action and how?". Thinking in this way, instead of looking at principles, she is aiming to find a way to act that creates the most benefit for the people involved. The normative theory of utilitarianism contains the argument that we should strive to make the world the best place we can, regardless of what kinds of rules have previously been set to guide our actions. (See, for example, de Lazari-Raek & Singer 2017.)

A timeworn example illustrating the differences between deontological and consequential ethics asks whether it would be wrong or right to pull a lever if it would mean killing one person but saving the lives of five. This

---

[4] Etymologically, the word deontology has its roots in the Greek word deon, which means ”that which is binding; duty.” (Read online April 7, 2020, at https://www.etymonline.com/word/deontology.) Thus, the word deontology literally refers to rules.

classical thought experiment known as the trolley problem was first discussed by Philippa Foot in 1967 (see Andrade 2019; Foot 2002). Many variations of the problem exist now, but this is the classical dilemma: Imagine there is a runaway trolley heading to a track on which there are five people tied up and unable to move. You have the option to pull the lever to save the people, while directing the trolley to head to a sidetrack where there is one person tied on the track. Would you do nothing and let the five people die, or would you pull the lever, diverting the trolley to the sidetrack and kill the one person instead? The trolley problem is considered to have great importance in discussions on medical ethics (Andrade 2019).

Someone looking at this dilemma with a deontological viewpoint would hold that killing is wrong in principle and thus, cannot be accepted: violating this principle would be seen to corrupt the whole social shared, rule-based moral system. However, another person may take a utilitarian, consequence-oriented perspective and argue that saving the lives of five would justify pulling the lever, even though this would lead to the killing of one person. Therefore, she would think that taking action and pulling the lever would be more ethically sound than doing nothing and watching five people die. This dilemma grasps the very epistemological conflict between deontology and consequentialism: Should we put more weight on the shared rules or, rather, on the consequences of our actions?

A different tradition under the umbrella of normative ethics is **virtue ethics**, a theory of ethics that emphasizes the virtues of individual people, not the governing rules or consequences of people’s actions. The theory of virtue ethics, having its foundation in Aristotle’s Ancient Greek philosophy (Aristotle 2020), emphasizes people’s characteristics to bear the burden of moral standards. The measure of moral conduct is thought to be a virtuous person who has learned to act in ways that realize high moral standards. Considering the origins of the tradition of virtue ethics in Ancient Greece, it is perhaps no coincidence that the Greek tradition of physician’s ethics started by Hippocrates builds its normative standards heavily on the physician’s individual characteristics. “In purity and according to divine law will I carry out my life and my art," states the Oath[5]. Rather than focusing on how a doctor overcomes a gripping moral dilemma, a healthcare professional approaching professionals ethics from the virtue ethics point of view inquires, "What kinds of people are professionals to be, at their best, in order to carry out their work with excellence and integrity? And what kind of virtues should they cultivate to attain these qualities?" (See, for example, Devettere 2002 about virtue ethics.)

Another theory in normative ethics is **care ethics**, a tradition that focuses on interpersonal relations and contextual factors. A great shift toward this thinking was spurred by Carol Gilligan's (1982) book In A Different Voice, in which Gilligan argued that women have a different way of thinking about morality than men. Care ethics was developed by feminists as a response to more traditional moral philosophy that was then criticized for setting the moral weight on individual actors, overlooking the web of social connections and the interdependence of people. Thinking in terms of care ethics, taking people's dependence and their vulnerabilities into account are central values. A person looking at healthcare questions from the framework of care ethics would stress responsibility, relationships and interpersonal connections to be weighed in decisions on a situational, case-by-case basis, rather than set rules and principles. (See, for example, Larrabee 2016; Brugére 2017.)

These theories demonstrate how there is no one "grand theory" of moral action, even though ethical theories pursue objectivity in their reasoning. Ethics is, rather, a diverse field in which defining a moral action is deeply dependent on the perspective taken.

---

[5] Read online April 6th, 2020, at https://www.nlm.nih.gov/hmd/greek/greek_oath.html. Translated by Michael North, Library of Medicine, 2002.

3 Social constructionism as theoretical foundation

Social constructionism sets the social scientific foundation for my research questions, data analysis, and findings. I introduce the basics of the theory in this chapter for a background understanding for my research framework.

3.1 Construction of the social world

Social constructionism is an expansive field of social theory and methodology that starts from the basic idea that meaning making happens in and through social processes. This means taking the perspective that people actively **construct** the social world they live in through the use of language and other social practices. Seeing the role of language in this way is a radical challenge to a more conventional assumption that language is merely a tool of interaction, a channel of reporting objective facts of the world or "a mirror to the soul." Social constructionism as a theory instead views language as the **constitutive** element of what **can** be thought and said, by whom and in what kinds of contexts. The use of language is thereby not seen as the channel of articulating an objective world outside the language; instead, language is seen as **constituting the very reality** that people observe in a certain time and place as solid and real. Language is, thus, viewed as a **pre-condition** for thought as well as a form of social action (Berger & Luckmann 1966; Burr 1995; Lock & Strong 2010; Edwards & Potter 1992; Potter 1996).

An important remark to make is that social constructionism should not be thought of as a theory within the "nurture side" of the great nature versus nurture debate (in short, the question of whether peoples' lives are determined more by their social surroundings or their individual genes). Social construction steps outside **both** of these dimensions and claims that it is the dynamic flow of the social process that brings both our conceptions of individuals as well as our social environments into being. Social constructionists are, hence, anti-essentialist in their view that they assume there to be no "true essence" inside things but that things are a **result of the way they are talked and thought about**. (Burr 1995, 5–6.) The key tenet of social constructionism, thus, holds that our knowledge about the social world, including the understanding of human beings and ourselves, is ”a product of human thought rather than grounded in an observable, external reality.” This is not a new or original view in itself—philosophers Kant, Marx and Nietzsche (although different in other respects) took this view, and this understanding of social construction is reflected in key sociological concepts of the 20th century, such as ideology and false consciousness (Burr 2015, 222).

An important distinction should be made here between the social world and the natural world. I do not attempt to make the claim that there would be no natural laws whatsoever—such as to claim that an apple would not fall from the tree if it was not talked about as falling. The epistemological view that I take still holds there to be natural realities that would stay the same regardless of their social construction—a person who is dead would remain (physically) dead no matter which way we talk about her. However, as a bioethics-oriented scholar, I cannot help mentioning at this point the curiosity of **brain death**, a concept that only appeared in the medical discourse after the development of organ transplantation in the 1960s. One may ask if brain death did not exist before this, or was it only defined after the need to categorize an ethical way—a boundary—to identify potential organ donors? This illustrates the way in which even terms that appear most naturalized and objective—such as death itself—can still include a dimension of social construction. (For more about the construction of brain death, its connection with organ donation and the controversy surrounding it, see Truog 2007; Miller & Truog 2008 & 2012.)

Therefore, I view that the way people see the world is not an either-or situation, as if to suggest that the world is **either** a social construction **or** a natural reality; I hold that it is both. However, the social construction I refer to concerns **the social rather than the natural world**, as I take the view that whenever there is social meaning making in defining objects of the world, social construction occurs. Jorgensen and Phillips (2002, 9) propose a useful metaphor that helps to think about difference between the social and natural reality with the example of a river overflowing its banks. The flood is a material reality when a river floods: it drowns everybody who is in the wrong place, regardless of their perspective, yet as people start to interpret the flood, a variety of constructions emerge. As a natural phenomenon, it can be interpreted as a meteorological condition caused by a heavy downpour or a consequence of global warming. Others would see it as political mismanagement: a failure to build appropriate dykes. Some would, however, see the flood as a manifestation of God's will—perhaps viewing it as God's anger over our sins or as a sign of Armageddon's arrival. The river flooding, therefore, causes different worldviews and interpretative frameworks to emerge. Suggestions about what courses of action should be taken are likely to be very different whichever way the event is interpreted. (Ibid.)

In this thesis, I understand healthcare ethics and its many professional forms as a social construction. I view these professional constructions not only as reflecting the views that professionals have about ethics but also as **constituting** their views about ethics by guiding the ways in which they talk about ethics. Like a flashlight pointing a circle of light and leaving other areas in the dark, professional constructions guide what kinds of questions the professionals ask about ethics and the ways in which different kinds of situations raise (or do not raise) ethical thinking in them.

Hence, based on the social constructionist theory, I hold that the way professionals understand ethics in the healthcare context is not a result of recording objective facts about things or their inner essences. Rather, it means taking the view that **what has become to be understood as professional ethics in a healthcare profession is a collection of historical, social and cultural ways of talking about the profession and organizing its practices in relation to its task and its interconnection with other surrounding healthcare professions**. This kind of social constructionist worldview, however, challenges the view that ethics would simply be objective and rational—and thereby appearing the same for everybody—by suggesting that ethics is, in fact, constructed differently from different viewpoints. My aim is to unpack the social constructions of the different ways of looking at ethics in the healthcare setting to create an understanding of the topic that extends over the limits of different professional cultures.

3.2 The dynamic and changing nature of social reality

If the world, including society and ourselves, is thought about as a social construction, it seems reasonable to ask whether individuals are powerless in front of such social "forces" around us. The answer is both yes and no. Yes, social constructionists think that the language, culture and shared patterns of thought that surround us do set a very strong base for the ways we come to think about the world and ourselves as individuals. And no, people are not trapped by the social world, because the social world is dynamic and constantly changing. The view I take here presents what Danziger (1997) calls "light" constructionism (as opposed to "dark constructionism"). Light constructionism suggests a more "hopeful" view of the world, emphasizing that people construct themselves and each other in social interactions, rather than being trapped by socially determinating forces. (See also Burr 1995, 21.)

One can think about this social environment as if it were a web of walking paths crossing through a forest to help grasp the way in which people's thinking is guided and constricted by social construction (for the metaphor of the paths, see Ahmed 2006, 16). The paths represent socially constructed **discourse**: the common ways of talking and thinking in our culture. The paths are there when we walk through the forest, and we have not created them ourselves in our solitude—instead, they have been shaped by people walking the same routes before us. There is always the possible alternative to walk off the beaten path; however, when we are in the forest, the environment makes it more expected for us to take the path. In fact, we are likely to take the beaten path without a second thought. One can similarly think about the socially shared meanings embedded in our cultural mindset as paths that we are very likely—even though not forced to—walk on. And consequently, the more we walk on these paths, the wider they become.

Social construction sets paths for our footsteps in this way. However, people are not powerless in front of these paths, because the paths can be changed. New paths can be created, and the old paths will eventually vanish if people stop taking them. It is helpful here to think about cultural "paths" that have changed in the past decades. For example, the socially shared meanings for what it means to be a man or a woman in one time and place set standards and expectations on how people may behave in their gender roles within that cultural environment. Differing from the general assumptions can be **difficult, but not impossible**, for individuals. However, as people participate in the social meaning-making process, they are **not only receivers but also contributors** to the social construction. The dynamic flow of the social process is, thus, a two-sided action, and this two-sidedness explains both why things so easily stay the same (as people keep taking the same paths) and why things change when something ruptures our old categorizations and normalizations (and people start making new paths). For example, the last decades in the Western world have shown an interesting shift in the cultural categorizations of homosexuality from a crime to a psychiatric disease into a more normalized lifestyle and sexual identity. This is a great example of discursive change, and it also illustrates the power that discourse has on peoples' lives. (See Fairclough 1992 about the dynamic and changing nature of the social world.)

3.3 Discourse and power

Discourse is an important concept for the study of the social construction of reality; in simple terms, it means all social practices of talking and writing that give meaning to something. Discourse is an interrelated set of text, talk, and practice that produces the social reality. We cannot understand and share a social concept in society (think about money, for example) without the discourse that constructs it. Discourses are shared and social by their nature, stemming out of the interactions between social groups and the societal structures in which the discourse is embedded (Phillips & Hardy 2002, 4). The different interpretations represent the different discourses that give meaning to the event in the previous example about the overflowing river (Jorgensen and Phillips 2002, 9).

An important element of social constructionism is the recognition that different social cultures always exist simultaneously alongside each other. Of course, the literal languages used in different countries vary, but different language cultures exist around us much more subtly all the time. This diversity represents the variety of discourse that surrounds us. It explains why, for example, differences in genetic heritance or life history aside, not all Swedish people are culturally alike, since many language cultures exist at once in one place, and those possible cultures enable different kinds of narratives for people. The collection of discourses in any culture is, thus, like a social jigsaw puzzle. This understanding of many levels of discourse operating at once also explains why we talk so differently when we talk to a friend from the way we would talk to a government official: The cultural script for the way we may frame ourselves, and the language we use, differs in these social encounters. We represent ourselves differently, and even view ourselves differently depending on the social context and the language we use to frame our identities and actions (Burr 1995).

Such different language cultures, or different "paths," exist around us all the time in this way, but some discourse has a heavier weight of meaning. Continuing the path metaphor, some cultural paths are equal to freeways and some are tiny footpaths crossing through a densely grown forest. This is where the important concepts of **hegemony** and **marginality** come into play: some discourse is more mainstream and therefore hegemonic, some discourse is more occasional and, thus, marginal. Mainstream discourse—hegemony—is characteristically hard to resist, and it (artificially) seems invariable and stable due to its long tradition and power. Hegemony can further be understood as the dominance of a particular perspective (Jorgensen and Phillips 2002, 7)—something that is typically so normalized in our cultures that it may seem even strange to think otherwise.

The concept of hegemony brings the idea of power struggle onto the map of social constructionism. As mentioned before, due to their dynamic social nature, discourses cannot be ultimately fixed in stone. However, struggle exists over about what shall be established as the **mainstream** way of interpreting something in a given time. Hegemony establishes a "taken-for-granted" nature that is seldomly questioned, even though history shows hegemonies to be in constant flux. Laclau and Mouffe's (1985) theory of hegemony suggests that while there are no fixed structures of meaning, a constant **struggle** over fixing a meaning exists (see also Jorgensen & Phillips 2002, 24–59). Thus, a discourse is a reduction of other possible meanings that could have been given to an event. It is this struggle over defining meaning and attempting to establish a hegemony that is interesting to critical discourse analysis as a research method.

Taking the idea of hegemony and power struggle further, discourse can be seen as a constant flux of negotiating identities that bear the weight of power with them. Through the negotiation of meaning, power relations in a society become naturalized, appearing as common sense. This power comes out of the negotiation and historical social struggle; it does not imply essences of things in themselves. The more discursive power a group is able to negotiate for themselves in society, the more influence they gain. Social constructionist thinking holds that there is no essence inside the people that would determine their value or status; it also holds that why we should think a doctor is prestigious but a road sweeper is not is not a reflection of objective facts but of power differences between social positions that have been created and are sustained in cultural discourse.

It is in this way of establishing identities of influence that discourse limits opportunities and keeps important doors open for some people and closed for others. Additionally, the **power of discourse** is not only the power of the **people** who use the discourse but the power of discourse **in itself**, meaning the use of language in itself. For example, taking a position in the euthanasia debate by framing it in medical language, with reference to medical science and text, is likely to have more influence on society than simply framing the argument around one’s own personal concerns about dying. (See Kuipers 1989 about the power of medical discourse.)

This leads us to the acknowledgement that **knowledge construction** goes together with **social action**, and as a form of social action, knowledge is also entangled with **power**. Through the lens of social constructionism, what a given culture represents as the **truth** is seen as being the currently accepted way of understanding the world and not an objective, all-encompassing fact (again, the previous distinction between the natural world and the social world should be made here, as the natural world does contain objective, unchangeable facts). Power flows into the social process of knowledge construction simply because people in powerful positions are typically in more enabled positions to participate in the kinds of forums in which knowledge is created, having their voices heard in institutions such as media, science and education. Many of the things we take for granted have been shaped by discourse that has been constructed by people with power and influence; therefore, many “truths” (the hegemonic discourses of our time) we take for granted have historical power written over them.

Discourse, thus, provides people their words and their talking space, so to speak; discourse enables and restricts the things that people from different backgrounds may or may not know and talk about, respectively. Again, it is important to remember that discourse is not set in stone. However, like the paths in the forest, cultural discourse has a way of silently showing us what kinds of options we find in front of us—the things we may know about and talk about without going against the grain and the kinds of agency we take in our lives. Pushing against the cultural assumptions, the paths provided for us, is possible but arduous and unexpected, like walking through a tightly grown and spiky rose bush hedge.

Nevertheless, there are always power struggles, and a great cultural shift occasionally occurs in which some powerful groups are replaced or are at least accompanied by others. My view is that this kind of social struggle process explains and illuminates the breakout of bioethics in the last decades and the way bioethics has challenged and changed some of the more traditional conceptions of ethics in the medical establishments.

4 Wrapping up the framework: healthcare professions and the social construction of ethics

In this chapter, I draw together the two main frameworks to create a clearer picture of how bioethics and social constructionism come together in the thesis. I first define the way I understand profession as a concept. I then introduce the research tradition of descriptive ethics and describe how my studies are in line with this branch of ethical research. I next address some key concepts of the thesis and their definition. After setting the foundation with these conceptual choices and clarifications, I move on to connect the social construction of professional ethics to bioethics to further define my research focus. Before returning to the research questions by the end of the chapter, I once more turn the lens back to diversity and uncertainty as the focal points for my thesis (and introduce how they are connected to thinking about an elephant).

4.1 Multiprofessionality and the definition of profession

Throughout the framework and research done for this thesis, I take for granted the idea that modern healthcare is ultimately a multiprofessional forum: It does not and cannot exist with only one profession alone. There may be lines of work that healthcare professionals carry out without multiprofessional co-presence and communication, but my baseline assumption is that the bulk of the healthcare work is defined thoroughly as a team effort that combines different kinds of professional expertise and skill. It is difficult, however, to draw boundaries around the concept of multiprofessionality by saying where, when and how much of healthcare work is defined by it.

The term **multiprofessional** refers to collaboration within a structure that follows a traditional way of working and a clear division of labor (Bergman-Pyykkönen 2017, 576). Working in multiprofessional teams refers to a co-presence of professionals sharing a task based on a clear (or generally clear) “who does what” marching order (compare to **multidisciplinarity** in Couturier et al. 2008, 342). Multiprofessionalism should be clearly differentiated from the neighboring term **interprofessionalism**. Unlike multiprofessionalism, interprofessionalism requires a meeting of different epistemologies through dialogue (Bergman-Pyykkönen 2017, 576). I take the idea that healthcare professions work multiprofessionally, but not necessarily interprofessionally, as a starting point for my studies.

Taking multiprofessionalism as a key tenet of the research in this thesis also includes taking up the question of what, in fact, constitutes a **profession** in the context of this thesis. The sociological literature on defining professions and their legitimations—as well as their critique—is vast, and to keep my focus on my research questions, I shall not address these professionalism debates here very thoroughly. However, it can be said that one line of argumentation around professionalism concerns the definition of the term. What constitutes a ”true” profession? What qualities distinguish it from a so called “semi-profession,” and what, in turn, constitutes a career but not a profession? (For interesting and somewhat critical perspectives on professionalism, see, for example, Larson 1977; Freidson 1986; Dzur 2008 and 2018.)

My starting point is that I see all the professional groups I study as professions regardless of whether they would all be strictly defined as professions (and not, for example, careers). The reasons for this choice are based on social constructionist epistemology. Each of the professional groups I study—medicine, nursing, and clinical ethics consultation—have come to exist by having a shared sense of **knowledge**, **identity**, and **ethics**. They work within the healthcare field with these social building blocks and bring their own vision of ethics into the entity of healthcare. Therefore, I take the constitutive view that they are all **healthcare professions** in the social world in the sense that the people working in these roles have been able to constitute themselves as professionals. They have **socially constituted** a profession within the cultural and professional climate of healthcare. In its rough simplicity, they exist as social constructions in the social world and the healthcare entity, even though definition of the concept of what constitutes a true “profession” may be conceptually debatable and complex to define in sociological terms.

Therefore, my understanding of what a profession means arises from the bottom-up (from social reality) rather than the top-down (from authoritative formulations). I take the term profession much as the Longman Dictionary of Contemporary English defines it: “A profession is a job that needs a high level of education and training.” I add to this simple definition of the matter that as I study **healthcare professions** only, I presume that within this social environment professions bear such a burden of proof that it seems reasonable to assume that they would not emerge as a “hoax” or just by accident. Thus, I view the mere existence of the professions in this rigorous environment as legitimating enough for the chosen professions to be constructed as research objects.

To sum up, I start with the view of **multiprofessionality** as a healthcare work reality, and I view this multiprofessionalism as consisting of **socially constructed professions**. I then use these conceptual coordinates to approach **healthcare ethics** in these professional domains as a complex social concept that appears in different shapes and forms.

4.2 Descriptive ethics

This thesis falls under the umbrella of descriptive ethics, as I study ethical understandings of healthcare professionals. Descriptive ethics—also known as comparative ethics—as a research tradition refers to the empirical study and analysis of culturally and socially prevailing moral reasoning and standards of ethical conduct. According to the Encyclopedia Britannica[6], this field is defined as ”the (observational) study of the beliefs and practices of different peoples and cultures in various places and times. It aims not only to elaborate such beliefs and practices but also to understand them insofar as they are causally conditioned by social, economic, and geographic circumstances.”

Whereas normative ethics attempts to identify a theory to establish standards for defining what is good and right, descriptive ethics studies inquire how actual people **think** about the good and right. Thus, whereas a

---

[6] Under Comparative ethics.

normative ethicist asks, “What should be done?”, a descriptive ethicist instead poses the question, “What do people think about what should be done?”. The descriptive task of providing understanding about the cultural dimensions of morality—moral conditions, values, virtues and norms—has typically been left out of philosophy, and it is typically carried out by intellectual historians, social historians, sociologists and anthropologists for example (Hämäläinen 2016, 1).

My studies belong under the umbrella of descriptive ethics. However, the substudies do not attempt to answer questions about what professionals “would do” in a certain practical situation; neither do I ask questions about what they “should do.” Rather, I inquire about the ways in which the studied professional groups abstractively, meaning **conceptually and theoretically,** think about **how they deal with the uncertainties and decide what to do**. An important distinction should be made here: There is a difference between studying what professionals **would do** and what they professionally—as a professional community with a tradition and ethical guidelines—**think about the ways such questions should be solved**. For example, going back to Anna’s case at the very beginning of the thesis, my research focus is not on how a professional would solve this case and what kind of action they would take in that situation. My focus is on the ways the professions approach cases like this is in their professional ethics, what kinds of ways they offer for solving such situations. What do the studied professions mark as important for their professional reasoning? What kinds of normative, theoretical or cultural assumptions are embedded in their ethical considerations? I study, therefore, in what kinds of ways the studied professional cultures present themselves as reflecting upon questions of healthcare ethics, not ethical decision making in action.

4.3 Professional ethics, healthcare ethics, bioethics: Some conceptual clarifications

I will next clarify the use of some basic concepts of the thesis to avoid conceptual confusion. As great umbrella-like concepts, not everybody uses words such as healthcare ethics the same way; the way of defining the key concepts is tightly bound to the framework of the thesis. Thus, providing further definition of the vocabulary is important for grasping both the framework and the findings of this thesis.

By the term **professional ethics**, I refer to the ways in which a given professional group defines its understanding of ethical professionalism. I view the professional ethics of different professions as social traditions that have been formed around each profession's task during its historical development. Thus, I approach professional ethics in this thesis as a **social concept.** Because of this approach, while ethics is typically associated with ethical principles, I do not study professional principles in this thesis. This is because it can be maintained that all the studied professions hold similar principles. They all put weight on advancing health with the widely accepted principles of healthcare ethics in mind: justice, beneficence, nonmaleficence and patient autonomy (Beauchamp & Childress 2012). Rather, I study the way people **use** principles in their practical theory for professional action—their professional **ethical worldviews**. This worldview consists of the ways in which people in a certain profession interpret ethical principles to guide their moral thinking and their action in their professional roles. With these conceptual choices in mind, I study ethical understandings of the different professional groups using the idea of diversity: I do not expect to arrive at a universal theory but rather to make visible the differences between the groups and explore them with an element of comparison.

I use the term **healthcare ethics** as a **theme** that entails all the areas of ethics related to the healthcare context. Healthcare ethics is the object of my studies, with its many forms and professional cultures. I view it as an umbrella concept for all the ethical analysis, guidelines and considerations that holds the patient's good in its focus in all healthcare professions. This includes different professions' conceptions of ethics and all the different topics concerned with ethics, such as the ethics of end-of-life care or organ donation. Therefore, the term healthcare ethics is the most encompassing, as well as the most unspecific, concept in the ethics vocabulary of the thesis.

The term **bioethics** is perhaps the most foundational for the perspectives and findings of this thesis. I define the term as an academic and practical **paradigm** that emphasizes multidisciplinarity and pluralism in its ways of approaching questions in healthcare ethics. In the way described before, I view the birth of bioethics in the 1960s and 70s as a paradigm shift from the more traditional profession-based ethos, especially in relation to medical ethics. (See Jonsen 1998 & 2000.)

This takes us to the concept of **medical ethics** that is probably the most likely term to cause conceptual confusion in this thesis. This is because I use the term both as a paradigm of healthcare ethics and as a concept under the title of professional ethics, referring to physicians' ethical worldview. Context reveals in which meaning I use the concept. Concerning the history of bioethics, I understand medical ethics as a paradigm comparable to bioethics. I approached the term as a professional ethics, a focus of interest for social scientific inquiry, when researching modern Finnish texts on medical ethics in the second substudy. Medical ethics, after all, is both: it is a way of thinking about ethics in healthcare as a profession-bound topic within the "long tradition" (Jonsen 2000) of medical ethics, as well as a worldview for physicians' everyday ethical practice: a professional ethics. I also use the phrase **physicians' ethics** to refer to the latter on some occasions.

The following figure illustrates the use of the concepts in this thesis. First, everything falls under the grand theme of **healthcare ethics**. Second, the themes are separated into **profession-based worldviews**, which form the object of my social constructionist research, and **paradigms**, wider historical traditions under which the different ways of dealing with healthcare ethics can be located.

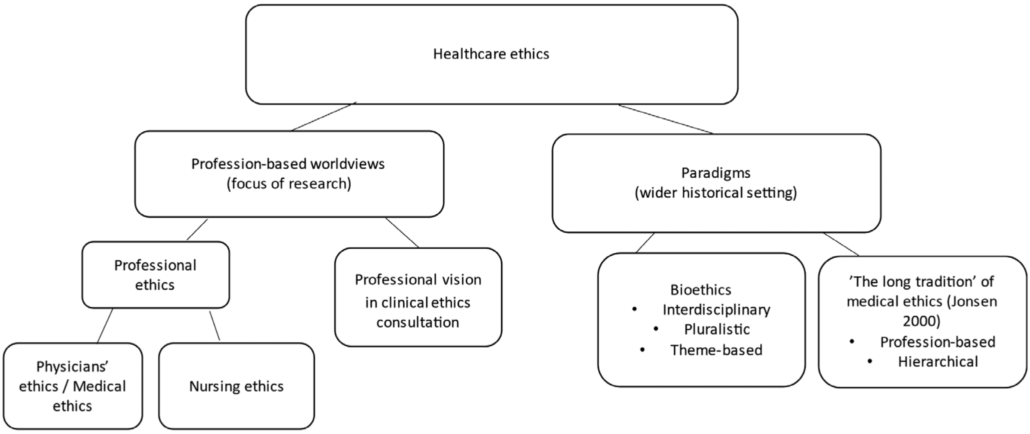

Figure 1. The key concepts of the thesis.

Another conceptual clarification concerns the terms **ethics** and **morals**. The concept of ethics is typically separated from the concept of morals in philosophy. Ethics refers to theoretically systematic work that reflects on questions about defining the good and right[7], whereas morals point to everyday moral life and people’s understandings. However, throughout this thesis, the two concepts do not stay categorically intact from each other in this way. As I study ethics in the empirical world, I delve into questions about how people talk about ethics and how they define it in talk and professional texts. Working on the topic from this angle, the concept of ethics becomes practically enmeshed with the concept of morals, because these words are often generally used as synonyms outside philosophy. Thus, while the word **ethics** cuts through my studies, a philosopher may be quick to add that what I am, in fact, writing about is the **moral** landscape of healthcare professions. However, because the word ethics is used by informants and the texts that I study, I use the same language in this context to ward off unnecessary conceptual confusion.

4.4 Sharing the table: Professions and the bioethics ethos

Understanding healthcare professions as social constructions is combined in my thesis with the more normative assertion that there is value in meeting ethical questions in a way that takes professional and social diversity into account. This bioethics ethos can be summed up to an image of people from different professions gathering together around the same table to talk about ethics, differing substantially from the more traditional model of each professional group having their own, profession-bound discussions. Therefore, despite the fact that my research lens is constructionist and

---

[7] The language and concepts of ethics are naturally much vaster and richer than suggested here. However, I use this simplistic language (the ”good and right”) to narrow down conceptual complexity, because philosophical ethics is not at the heart of this thesis. Thus, I do not attempt to suggest that defining what is good and what is right would simply be the center of ethics as an academic discipline. I hold that ethics is a multifaceted, critical and systemic inquiry of moral justifications and moral phenomena and cannot be reduced to these simple concepts.

therefore non-normative, my perspective on the topic has a normative quality, because throughout the work I highlight diversity and interprofessional dialogue as central values.

The reverse side of taking this viewpoint is raising a **critique of an insular professional systems of ethics**. I take a critical stand toward social systems that categorically raise some professional understandings of ethics above that of other professions, thereby creating a hierarchy in which professional status determines whether one is able to participate in ethical dialogue and decision-making processes in their professional role. I acknowledge that **decision making** must be based on hierarchy—after all, ultimately somebody must be in position to make the decision—but I hold that this does not have to include a hierarchy of moral knowing in which other professionals' or stakeholders' viewpoints are systematically and institutionally not heard in terms of their moral views. This is based on separating value decisions and moral discussions from expertise-based territory: There is a difference between making a medical decision based on a patient's symptoms, on the one hand, and making an ethical decision based on views of the quality of life or a good way to die, on the other hand. The latter symbolizes value questions in which no profession alone can demonstrate having supreme expertise, since value questions cannot be solved by generating more expert information alone.

It should be noted that the tension between expert decision making and pluralistic or democratic decision making is much greater than what will be addressed here. This tension, in fact, is one of the oldest controversies in political and moral philosophy. Few would deny the importance of expertise, and yet, for there to be any reasonableness in pluralism and democracy, experts cannot make all the decisions for others. The central and difficult question, then, is where the line should be drawn. (See Lagerspetz 2008.) I am taking the view here that a rough line should be drawn between technical knowledge (in which expert agency is most needed and legitimate) and moral knowledge (in which at least some form of collective agreement and shared agency is necessary).

My study setting starts from the idea that professions construct their field of inquiry and professional lifeworld in and through social action that is tied to the profession’s history, culture and position of influence in society. Lifeworld is a concept used in philosophy and sociology that refers to the world experienced as a lived entity as opposed to theoretical or analytical interpretations of life. The concept of lifeworld includes everything that is self-evident and given for an individual, group or culture. Theoretically, the concept is wide and nuanced, and this theoretical scrutiny falls out of the scope of this thesis (for a deep understanding of the concept, see Husserl 1970; Habermas 1987b). As a starting point, I assume that the studied professions have formed themselves over a long period of time—through a historical and social process of negotiation—into the form in which they appear now, including the duties they take on and the expertise they bring to the table. This idea is extended to their professional understanding about ethics: taking the viewpoint of social constructionism, I view each profession as having formed **an ethical worldview** that guides their understanding of ethics in their healthcare roles. I strive in my studies to understand what kinds of taken-for-granted qualities are written into these worldviews. The end point of these inquiries is to bring the findings in this thesis together, figuratively, around the same “table,” equivalent to the bioethics ethos. This involves an aspiration to create understanding about the barriers that may prevent this kind of interprofessional ethical dialogue in order to cross them.

The next figure demonstrates the entanglement of bioethics and social psychology in this thesis. Social psychology is my original scientific discipline that shapes the theory and method of my studies. Combining these fields, the social construction of ethics in healthcare professions emerges as the substudies’ focus of interest.

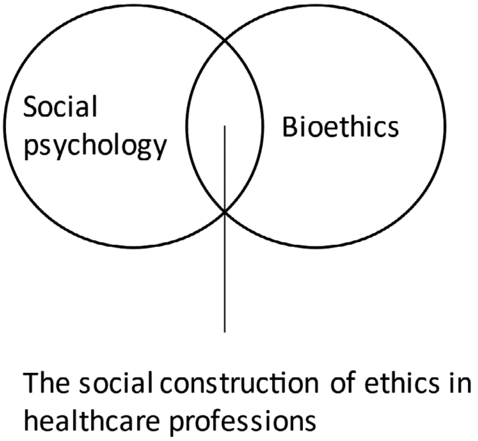

Figure 2. The research focus lies between two disciplines, social psychology and bioethics.

I approach ethics as an empirical term packed with social meaning and moral rubric from this theoretical foundation. Toward the end of the thesis, my work also takes a more normative turn, because I use my empirical findings to consider practical implications for going further. This is not to argue that my empirical work would seamlessly lead to solid normative moral philosophical claims. Rather, my intention is to awaken the interest of others to discuss my research and views and to take the conversation further. My empirical work bears no normative rigor, but by deepening understanding about the nature of ethical diversity in healthcare, my inquiries open horizons toward asking questions about what should be done about the current situation.

Social scientific descriptive ethics studies can sometimes be understood as “mere” descriptive projects that may not necessarily offer relevant knowledge for philosophers (Hämäläinen 2016). I want to slightly push this traditional boundary to make the claim that my descriptive study also offers a viewpoint for philosophers’ considerations. Many reasons exist to think that descriptive studies could, in fact, enrich the work of philosophers and vice versa. Normative ethics is not only normative by its nature but is always in some way based on an interpretation of the abiding moral situation (ibid., 3). It is in this capturing of the moral situation that descriptive studies are essential and fruitful not only for social science but also for moral philosophy. However, a descriptive study aiming at creating an articulation of the present moral situation “involves covert normative emphases and implications that should awaken a philosopher’s critical instincts” (ibid.). Thus, whereas normative philosophy is not merely normative, descriptive ethics is neither just descriptive; rather, it connects to the kind of normative struggle and conceptual work that philosophers are particularly well prepared to deal with (ibid., 6).

It can be thought that by investigating the social construction of healthcare ethics, my research topic is constantly caught between the worlds of social science and philosophy. This juxtaposition puts the thesis in a place in which I occasionally sacrifice the scientific elegance of both academic fields in order to make claims that I find beneficial or insightful in relation to the topic. This crossing of disciplinary and methodological consistency is done with deference to the late Daniel Callahan, one of the founders of bioethics as a field of study. He defined the rigor in bioethical inquiry to be less about disciplinary or methodological sophistication and more about “the rigor of unfettered imagination, an ability to see in, through and under the surface appearance of things, to envision alternatives, to get under the skin of people’s ethical agonies or ethical insensitivities, to examine things from many perspectives simultaneously” (Callahan 1973, 71).

4.5 Professional diversity and the meaning of perspective

Adapting the perspective of multiprofessionalism in this thesis also brings forward the idea of **professional diversity**. It may be obvious that advancing health and the widely accepted healthcare principles are shared by all healthcare professions, yet my viewpoint is that in healthcare—as in society at large—there always exists, simultaneously, profoundly **different ideas** of what is good and what is right. In other words, this idea of diversity indicates that **different ideas about ethics exist alongside one another**. Principles, thus, depict the moral rubric only on a general level, leaving the diversity of the social world out of their focus. Diversity of viewpoints goes not only for the different kinds of patient populations (which is normally expected) but also for the healthcare professions. With this beginning in mind, I explore multiprofessional healthcare and the prevailing ethical understandings with an attitude of exploration and pluralism.

As a result of my multifaceted explorations, multiprofessionality and professional diversity in the healthcare field unfold in this thesis as a **polyvocal collection of perspectives**.[8] Hence, I do not make a direct study of the theme of multiprofessional collaboration or diversity in themselves. Instead, I hold these qualities of healthcare in the silent background while studying different professional views one by one. What arises is the realization that ethics can be viewed as a matter of perspective, yet the healthcare reality of multiprofessionalism ensures that the different understandings **do not exist in silos**. Instead, they live alongside each other, and this social reality of diversity anticipates constant negotiation with an inclination for struggle. Seeds for a potential collision of worldviews are also present (even though in everyday healthcare this struggle may look more like shadowboxing than open rivalry).

Thus, multiprofessionalism suggests that **differences of perspective** exist simultaneously in healthcare. Allan (2007, xix) points to an old story of a group of blind men examining an elephant to illuminate the importance and meaning of perspective. Standing in different locations in relation to the elephant, the man standing closest to the tail determined that the elephant is like a very smelly rope. One man examining a leg of the elephant concluded that the elephant is like a tree trunk, while another man touching the trunk said, in turn, that the elephant is like a hose. One could claim that all these men were wrong, but one might as well say that they are all equally right about the elephant. After all, the elephant is all these things. What you may "see" of the elephant and how you describe it **simply depends on where you are standing**.

Moral uncertainty is "the elephant" throughout this thesis. I start with the understanding that all professions confront uncertainty from their own professional viewpoints and find ways to deal with it. Understanding

---

[8] It should be noted that this idea of polyvocality and the acknowledgment of the different voices come very close to Mihail Bakhtin's theoretizations. However, Bakhtin's theory is wide and complex, so I have left it out of this thesis, but connecting Bakhtin with bioethics could be an interesting idea for future work.

uncertainty as the elephant in this way means taking the stand that, even though there are different voices heard in healthcare ethics, everyone is still talking about the same thing: They are talking about the ways of understanding, confronting and dealing with the uncertainty entangled with the realities of patient work in the healthcare setting. Patient work is the very center of healthcare—its raison d'etre, justification for existence—and no healthcare profession can exist outside of its influence. My premise, thus, is that even though things can look different from different angles, healthcare ethics centers around the very uncertainty of meeting patients as persons. Thus, I take the view that moral uncertainty stemming from this social reality represents the one elephant that all the professions are talking about.

4.6 The research questions: Developing the focus

The research questions presented in the introduction chapter capture the realm of inquiry in this thesis only on a general level. I now turn the lens on developing the questions more explicitly.

In the first substudy on the **professional vision** of clinical ethics consultation (CEC), I explore the ways in which the interviewed ethics consultants present their area of expertise and practice. What do they "see" through their professional lens as clinical ethics consultants? What is constructed as significant within this professional vision? How does the profession respond to what it marks as significant; in other words, how do the professionals deal with the practicalities that they see as important, and with what methods do they approach these things? I seek to understand the nuances of social construction that shape ideas of what it means to be a clinical ethics consultant by exploring these questions. This is important, because such a social landscape can be so subtle that it seems almost invisible from the surface if the professional discourse is not systematically analyzed and brought to light in this way. Making the invisible visible, then, provides both a deeper understanding about the profession and a possibility for turning things that are often nuanced and intangible into a more palpable and concrete form.

The second substudy delves into Finnish professional texts on medical ethics and nursing ethics. The research interest is on understanding the worldviews of the two professional domains regarding their ethical discourses. I am also curious about identifying the **differences** between the ways that Finnish nurses and physicians construct their professional ethical worldviews. I explore how the two studied professional subcultures make sense of ethics—the ways in which they bring the widely abstract concept of professional ethics into the domain of providing guidance for concrete and practical work. I ask, what appears to be significant to the professional groups in their texts? What is taken for granted? What is expected from a professional about living up to the ethical ideals of healthcare? What kinds of ideas are highlighted and what, in turn, are left in the margins? My aim is to make the hidden social constructions visible in order to open ethical dialogue about, and between, the two professions. Creating this kind of in-depth understanding can be helpful for understanding the differences and, thereby, supporting interprofessionality in healthcare teams.

The third substudy concerns moral expertise in clinical ethics consultation. Based on secondary analysis of the first substudy while drawing from social constructionism and post-structuralism as my theoretical frame, I envision a way of seeing moral expertise in CEC as **the locus of an inherent paradox**. I argue that the foundation of CEC as a professional practice is based on an ideological struggle between pluralism and expertise—inclusion and exclusion—and that it is this struggle in the profession that creates an inner tension: a paradox. However, I argue that this paradox does not necessarily lead to an insurmountable contradiction; rather, it can be embraced positively as a guarantee of keeping moral space open.

What is common to these individual essays are the themes of **healthcare ethics**, **diversity**, **uncertainty** and **multiprofessionality**. These themes are continuous, but the perspectives differ. I study the ethics of nursing and medicine as independent professional constructions. However, I do not study professional ethics in clinical ethics consultation in the same way but, rather, the professional vision of dealing with ethics as the focus of clinical ethicists' expertise. The professional vision of clinical ethics consultants, thus, expands horizontally over the topics of both nursing and medical ethics. The figure demonstrates this idea.

Figure 3. The studied professional discourse. Clinical ethics consultation expands horizontally over the themes of nursing ethics and medical ethics.

The substudies are united theoretically and thematically, but another connecting link is the attitude of approaching each inquiry with a tolerance for and curiosity about inner tensions, inconsistencies, and paradoxes. It could be said that from these thematic and theoretical foundations, my own perspective of “the elephant” is one that sees the elephant as a patchwork stitched together from different kinds of social meanings that all present one worldview of dealing with moral uncertainties in the healthcare context. Those different worldviews have each developed historically and socially in diverse times and places. They have also grown out of necessity to answer different kinds of social needs, reflecting different positions of social influence and power.

5 Methods

I start the shift from setting the foundations for the substudies to introducing the studies themselves in this chapter. I present the data and its collection methods as well as the methodological choices made. I consider the ethical dimensions of the research and research integrity at the end of the chapter.

5.1 Qualitative inquiry and knowledge interests

All empirical work in this thesis is qualitative. I have used both interviews and textual resources as research data. Regardless of the source of the data, all analytical readings have ultimately been done with text format data, because interviews have first been transcribed into text to allow closer analysis. The third substudy is not addressed in this chapter, because it does not involve direct empirical analysis.

It should be noted that qualitative research does not aim at statistical or numerical generalizability; rather, it aims to create an in-depth understanding that can also be applied outside the original research data. The bioethics perspective I am taking leads me to explore the healthcare professions' understandings of ethics in a way that can be described as depicting the combination of both an emancipatory knowledge interest and a hermeneutic research interest. This definition of research interests is based on Habermas's (1987a) separation of the interests of knowledge. However, I have taken the liberty to define my research to reflect both hermeneutic and emancipatory qualities, even though, strictly following Habermas's theory, my research should be categorized as emancipatory. I have made this choice to emphasize my fundamental aim to understand the in-depth worldviews of each profession and not to highlight the critical attitude toward power imbalances only, even though this emancipatory quality cuts through my studies as well. Additionally, some analyses I have made are more hermeneutic and some more emancipatory throughout the thesis.

My studies reflect the hermeneutic research tradition in its ambition to generate in-depth understanding of the many professional perspectives on the topic. Qualitative research is most suitable for gaining a rich description that taps into cultural ways of understanding ethics; therefore, a similar result could not be acquired with survey data. I have chosen the critical discourse analysis as a research method because it has the potential to make tensions and power struggle visible. This is important because by understanding the tensions, it becomes possible to critically weigh upon questions about professional power in the healthcare setting. This choice reflects the emancipatory research interest that seeks to identify marginalizing discourse and power claims that may work as barriers to reaching the ideal of interdisciplinarity and dialogue. Such an emancipatory research interest also aims to create awareness of the changeability of the social world and the potential societal alternatives available.

5.2 Interviewing clinical ethics consultants: Critical discourse analysis on interview data

My first substudy considers the professional vision of clinical ethics consultation and is based on interview data. In this chapter, I address the thematic interview as a research method, the nature of the data in the study, the method of the analysis, and describe the phases of the analysis process.

5.2.1 The semi-structured interview

The interviews were carried out with a semi-structured interview model, also known as the thematic interview. Interviews are among the most common ways to collect qualitative research data, and there is great variance in how much structure the interview framework may contain. One great difference between more structured and less structured interview formats appears in relation to the role offered to the interviewee: in less structured formats, the person interviewed is more a participant in the meaning making rather than a conduit from which information is retrieved. Because of this difference, very heavily structured interviews are typically used to gather quantitative data, whereas more open-ended and less structured interviews are more typically used to attain the kind of rich descriptions that are quintessential for qualitative inquiry (Dicicco-Bloom & Grabtree 2006, 314).

The semi-structured interview model means using a partially predesigned interview format that focuses on bringing up certain themes while leaving room for the interviewees to offer new meanings to the study topic. This method has remarkable potential for qualitative work, because it gives room for an interviewee's narratives to unfold in unexpected ways. The attitude of unexpectedness and open-endedness during the interview makes room for the multiple levels of meaning and storytelling to unravel. Getting access to this kind of multilayered data then prompts a possibility for the researcher to discover a rich qualitative understanding about the research topic (Galletta 2012).

All the interviews were in-depth encounters in which I aspired to bring the interviewee's narrative into voice. The term in-depth here refers to asking the interviewees follow-up questions in response to their initial answers to elicit a more comprehensive narrative. The interviews' focus intended to achieve clarification and understanding about the topic. My knowledge about ethics consultation was meager when I began the interviews. This was a good thing, as it allowed me to naturally refrain from rigid preconceptions. The kind of "beginners mind" of aiming to have as little predisposition as possible and having an outsider position on the topic can enhance the depth of the interviews, because the interviewee does not expect the interviewer to know a great deal about the topic and will thus describe her thoughts in detail (Tinker & Armstrong 2008). This positioning of the **inside knower** (the interviewee) and the **outside inquirer** (the interviewer) has the potential to bring the more silent, taken-for-granted assumptions into view. This is an especially important and interesting feature for discourse analytic research, because one of the main focuses for the analysis is the unfolding of what is taken as given by the informants and, thus, what kinds of understandings appear to be normalized and hegemonized in a way that is seldom openly questioned.

5.2.2 Data

The study comprises 11 thematic, one-on-one, in-depth interviews with ethics consultants working in five different university-affiliated hospitals of one large urban area in the United States. The interviews vary between 45 and 100 minutes in length, and they were made between October 2014 and May 2015. I met separately with each of the 11 interviewees in private spaces free from outside distractions, either in their own offices (n = 5), general hospital meeting rooms (n = 3) or in general university meeting rooms (n = 3).

The interviewees were reached through a central contact person located in a university-based bioethics center who identified people in the affiliated hospitals to be interviewed. The bioethics center was a natural place to start making connections, because its main purpose is to enhance and sustain interhospital connections and communication in a wide variety of topics related to clinical bioethics. The initial contacts and meetings were performed by e-mail. The e-mails consisted first of a briefing letter about the study and later of practicalities about setting up the dates and times for the interviews.

The interviews were audio recorded. Before starting the interview, the interviewees were verbally asked about their voluntary consent to the study and whether they felt they had been sufficiently informed about the study before participating. The information about the study was given by e-mail beforehand, and the interviewees were given the opportunity to ask questions before the interview. The solicited verbal consent was captured on the audio recording.

I transcribed all recordings manually to familiarize myself thoroughly with the data before moving on to the analysis phase of the study. This comprehensive effort to make myself closely conversant with the data is a natural phase of qualitative research inquiry, because the aspiration is to understand the object of research in depth through ways that cannot necessarily be captured on a more surface level of inquiry.

The interview data add up to 148 single-spaced pages in text format. The study's focus is on the inner logic of the statements—on the question of **what** is being said rather than the **how**—so the interviews were transcribed in the simplest possible way. Thus, I did not pay close attention to the microstructure of the speech while making the transcription. I made an exception to this rule by including extended pauses, whispering, laughter as well as laughing tone on the transcription, because these nuances seemed significant and gave more life and meaning to the text being analyzed.

5.2.3 Method and analysis

Critical discourse analysis is the method used to analyze the data. Discourse analysis encompasses a wide range of social scientific methodologies that center around the study of language. It is specifically about language "in use" (van Dyjk 1985, 1), because it aims to make sense of living language by making explicit the typically implicit ways in which language constructs the social world. **Critical discourse analysis** (CDA) is a form of discourse analysis typically used in research that seeks to identify the ways in which power relations and inequality—such as racism, misogyny and other marginalization—are constructed in the use of language. A still relatively recent research method, it emerged into the social scientific methodology literature in the late 1980s, led by writers such as Norman Fairclough, Ruth Wodak and Teun van Dyjk (Blommaert & Bulcaen 2000, 447).

My first substudy exploring the discourse constructing the professional vision for clinical ethics consultation (CEC) uses critical discourse analysis as a method of exposing hidden cultural constructions and tensions embedded in the professional discourse appearing in the interview data. I do not use a tightly power-focused version of CDA, because I do not delve into questions of power in a substantial way. I use instead the CDA approach to explore the data with **a critical view that aspires to show hidden connections and causes** that are usually not transparent to the people involved in the discourse. I use the CDA method to create critical awareness of the general structures of knowledge that shape the CEC professional domain. It is important to note that the term critical here does not refer to criticism. It refers, rather, to being sensitive about identifying potentially hidden structures and tensions within the professional discourse.

I also take from the CDA theory and method the **structural** (rather than situational) **understanding of discourse**. I assume my interviewees will describe their profession to me in a way that utilizes meanings that exist outside the interview situation, as if there was a "bank" of knowledge somewhere from which they withdraw meanings. This bank is the structural web of discourse that creates the object of the study, the socially shared professional vision. However, I understand these social structures manifest only a temporal and partial fixity, seeing language and discourse production in a flux of constant struggle and change. This post-structuralist view differs from the structuralist view in which discursive structures are seen as unitary and fixed (Fairclough 1992, 66).

I start the discourse analysis on the CEC interviews from the premise that a socially shared understanding of professional vision exists in the data, even though this may not be evident on the surface. Like the metaphor of the paths in the forest elucidating social constructionism earlier, I presume that clinical ethics consultants share discourses that construct these kinds of discursive "paths" in their professional domain: I assume that they **share an understanding about what their profession is all about**. I then set out to make sense of the pieces that construct this understanding of the essential "what", "why" and "how" of clinical ethics consultation as a professional field. Just as professions ultimately become legitimized by convincing outsiders (Freidson 1986), I view my outsider position as providing a beneficial vantage point for mapping out the professional vision of clinical ethics consultation.

Professional vision is a key concept in this inquiry. The idea that each professional group holds a specific professional vision crystallizes the essence of why a farmer and an archaeologist may examine the same patch of dirt and yet see different phenomena in it (Goodwin 1994, 606). I start with the premise that central to the organization of a profession is its ability to construct a professional discourse that shapes events in the profession's domain of scrutiny. Professions form their specific language and practices in a social process, and the result of this construction forms the meaning, purpose and methods of the profession that are incorporated into the profession's realm of inquiry and action. Some phenomena are made salient, while some others are faded into the background through the construction of the professional vision (ibid., 628). My task is to explore what kinds of discourse, then, appear in the data as meaningful for the professional vision of CEC – in other words, what is taken for granted, what just "is" without further questioning and explanations, as if it is hidden in the data.

It should be noted that I am not referring here to professionalism as a formal and legislative structure. Clinical ethics consultation is not currently a formally professionalized field in the U.S., so I refer to professional practice as a bottom-up rather than a top-down construction. The interviewees were comfortable with the terms professional and profession, and I did not counter this understanding. However, this wording does not aim to take a stand on the debate whether clinical ethics consultation should be formally professionalized or not, because this would go out of my domain of expertise and inquiry.

The data analysis proceeded in **three phases**. However, before explaining the process it should be mentioned that discourse analysis seeks to identify what is hidden in the text as its taken-for-granted qualities; thus, being too systematic or mechanical in the analysis phase undermines the very basis of discourse analysis, because this would easily lead to reification of the concepts in the text without questioning them. A very systematic approach to the categorization of the concepts in the data—such as traditional content analysis—is, therefore, counterproductive to discourse analysis; rather, a more open-ended and flexible iterative approach is needed. Therefore, it is difficult to set one systematic ”recipe” about how one should carry through an analysis process. The researcher’s role is, rather, to develop an approach that makes sense in the context of the study and the particular research questions. (Phillips and Hardy 2002, 74.) Keeping this in mind, it is likely that another discourse analysis study may proceed in a different format from mine.

Reading through the data in the **first analysis phase** was an attempt to accumulate initial insights and intuitions about the data. However, I had already become deeply familiar with the data before the analysis, because I had performed the arduous process of manual transcribing. The purpose of this laborious work was not just to get access to the data in written format (which could have been done more easily and automatically with transcription software) but was also to thoroughly familiarize myself with what was in it. I made notes of my early observations during the first phase of the analysis and wrote down questions I wanted to investigate more closely. I approached the data with the assumption that structure and order exist in it, even though they may be difficult to identify. I paid attention to what appeared to be present in the data but not said out loud. I approached the data with a state of wonder and curiosity about what may emerge in this first phase.

The second phase consisted of a more systematic reading. I identified certain themes that appeared to repeat themselves in the data and wrote them down with illustrative data samples. I paid attention to the level of explicit explanations and justifications that were made. I wanted to pin down areas that were **not** explained thoroughly but were rather "just there" because I was after the "taken-for-granted" qualities. At this point, I also queried what kinds of silent assumptions appeared to be giving these contents their unquestionable nature. The categories I pinned down in this second phase had to be the kinds that would actualize in different kinds of situations and settings, not only in certain specific examples. Thus, the discourse I was after had to raise the abstraction level from specific examples into a more "umbrella-like," horizontal view over the data.

The third phase was testing the categories. I read through the data again, keeping an eye on how well the categories developed in the second phase appeared to fit together with the data. Some initial categories now needed to be modified or even rejected. The phase of testing and modifying the categories elucidate the back-and-forth movement the researcher makes in the iterative process of qualitative research: The steps do not simply progress; rather, the researcher must remain flexible to move between the phases to obtain the best out of the data. This analysis process differs greatly from quantitative research in which the categories of research are chosen **before** the data collection; it is the other way round in qualitative research, because the categories are only defined **after** the data is collected (McCracken 1988, 16–17). This is because the researcher keeps definitions as open as possible up until the analysis phase of the study to arrive at a rich description of the research topic.

Carrying out a qualitative analysis is typically an iterative process like the one described here, but there is no coherent set of rules regarding how to perform a qualitative analysis. The understanding that emerges out of the qualitative study depends largely on the questions asked of the data, the research methodology, and the theoretical framework. The results are also equally tied to the researcher’s imagination and creativity in being able to give names to things and to identify patterns in the data. Thus, qualitative research contains aspects of researcher subjectivity that would simply be alien to more positivistic and quantitative methods of inquiry. The significance and success of the qualitative analysis, finally, boils down to what happens after it is published, because the greatest test to which the qualitative analysis is put lies completely outside the researcher—it is the test of whether the study resonates with the people it addresses.

5.3 Exploring nursing ethics and medical ethics: Critical discourse analysis on text data

I explore the ethical discourse in Finnish professional texts on medical ethics and nursing ethics in the second substudy. I bring the analyses of both domains side by side to enable an element comparison to arise. Understanding the differences provides insight and understanding about the ethical worldviews of both professional cultures.

5.3.1 Data

The data consists of two textbooks on professional ethics, one for nurses and one for physicians, and the codes of ethics for both professions. Next, I introduce the basic elements of this data.

The codes of ethics of both professional groups are written by national professional associations. The associations have published their codes of ethics on their websites, and I used these web resources as my data source. The code of ethics for nurses, published by the Finnish Nurses Association (see data source Sairaanhoitajaliitto 1996 and appendix 2), had originally been accepted by the Association’s general assembly on September 28, 1996. The text, 468 words in length, is presented as having remained unchanged at least up until I analyzed it in December 2016, 20 years after it was originated. The medical code of ethics, also analyzed in December 2016, is provided by the Finnish Medical Association and its length is 306 words (see data source

Lääkäriliitto 2014 and appendix 1). The latest version was updated and published on December 12, 2014 at the time of its analysis.

The main bulk of the text analyzed consists of the professional textbooks. The physicians' textbook (254 pages long) is the 7th updated edition of the text, published in 2013. The publisher is the Finnish Medical Association, and the text within can be seen to represent a canonical, official view of the profession. This canonical undercurrent is highlighted by the fact that, apart from the first seven chapters on pages 11–37, most of the pages in the book do not identify their writers. However, the book identifies three editors and the association's ethics committee, comprising of 20 people, as the editorial board. In addition to this, 61 names are listed as a panel of experts consulted for the book. The book is represented to be the outcome of a process of negotiation between the listed members of the ethics committee, consulted experts, and the book's editors. (See data source Saarni, Kattelus & Nummi 2013.)

The analyzed nursing ethics guidebook differs from the medical ethics book in format; it consists of articles by identified writers (14 articles and 33 writers in total) who represent both nursing science scholars and field practitioners. The book is 184 pages long and is part of a "year book" series in which the association takes up a different topic relevant to nursing each year, ethics being the topic of 2012, the publication year of the book analyzed. Thus, the book embodies manifold perspectives on the topic and cannot be thought to present a canonical view in the same way the medical ethics book does. (See data source Ranta 2012.)

Differences about the professional cultures of ethical discourse, thus, arise not only in the contents of the books but also in their formats.

5.3.2 Method and analysis

I use the same method of critical discourse analysis as in the earlier substudy, but this time on naturalistic data. This refers to data that are "neither elicited nor affected by social researchers" (Potter 2008). Thus, in this study's context, this means the text data I have used existed before my inquiry into them and, unlike the interview data in the first substudy, the existence of the professional texts is not in any way related to my research efforts.

The differences between analyzing interview data and text data[9] are more in the form of the data rather than methodological differences. Text data is "cleaner" in the sense that it has been more thoroughly thought out, and most of the potential discontinuities, topical overlap and unfinished ideas are likely to have been edited out of the final text. The text data also differs from the interviews in the rarity of first-person narrative. Being professional texts, the text data was also more formal and contained less hedging. A hedge is a marker of uncertainty in language, a mitigating word or phrase that makes a statement less forceful (wordings such as "sort of," "kind of," "maybe," "almost," or "somewhat") (Fairclough 1992, 122).

The CDA method used in the text analysis is based on the same theoretical and methodological choices as were made in the previously presented interview study. The focus is once more on identifying hidden structures built into the text, with an interest in capturing the deeply embedded discourse—in other words, the things that appear to be taken for granted. I work from the social constructionist perspective that holds that what passes as "common sense" in the text is constituted through the use of language. The language used paints a picture that appears to the social world as solid and real (Phillips and Hardy 2002, 2), and I am curious to uncover what kinds of understandings about **ethics** appear this way in the texts. With the discourse analysis made, I aim to make the familiar strange by directing attention to the ideas that typically do not receive such scrutiny—because they are, by definition, taken for granted. Making the invisible visible, then, raises questions that are not typically asked; as a result, fresh perspectives on the research topic can be opened.

I take a more critical position in this study in relation to questions about power than in the previously described study about the professional vision of CEC. CDA is markedly a method of paying attention to and exposing a power imbalance (Fairclough 1992, 2001, 2010); thus, I aspire to identify subtle ways in which discursive power may play into professional ethics in the texts. This is an especially fruitful perspective for this study, because it brings two entities

---

[9] Interview data is also technically text data, because the interviews were analyzed in their transcribed format. However, I refer here to the naturalistic text data for which text is the original form.

(medical ethics and nursing ethics) under scrutiny at once, thus allowing an element of comparison to arise. By analyzing two professional constructions of ethics, my lens as a researcher accesses various "points of entry" into the topic of healthcare ethics and opens up questions not only about the discourse of professional ethics but also about **relations** between the two professions. The comparison creates a possibility of a greater understanding of healthcare discourse to emerge, because "discourse is not simply an entity we can define independently: we can only arrive at an understanding of it by analyzing sets of relations" (Fairclough 2010, 3).

The analysis proceeded in **four phases** similar to the first study. I started with the presumption that some sort of order exists in the data even though this may be difficult to pin down at first. **In the first phase**, as I was carefully reading through the texts, I formed a set of primary premises about what appeared to be embedded in the data. I paid close attention to what was said and how, to what appeared to demand further explanations in the text and to what just "is there," as taken for granted. This scrutiny was more relevant for the textbooks than the codes of ethics, because the short and statement-like codes did not make such nuances visible in a similar way.

I started the formation of interpretive categories in the **second phase**. I read through the data again, looking for contents not only abstract enough to actualize in a variety of examples but also specific enough to bring something concrete out of the data. This was the most difficult and time-consuming phase of the research. **The third phase** was the testing of the categories. I read through the data again, asking whether the discourses appear throughout the data in significant ways. This phase required some interpretive categories to be modified and some rejected altogether, returning to phase two. **The fourth phase** was to read through the data again to make a final check on whether the analysis still appears accurate.

The iterative process of qualitative research is best summed up as striving to achieve an interpretation good enough to crystallize some insights into a thought-provoking analysis yet accepting the reality that not everything about the data can be said. Rich, qualitative data can be fragmented into so many topic areas and perspectives that the researcher's ability to grasp it all and imagine possible alternatives is easily compromised. Additionally, even the best researcher must make some sacrifices regarding what to include and what to exclude in the analysis. In the end, the iterative back-and-forth analysis process could continue forever, but it must stop somewhere. This “stopping” is the final analysis presented, which by no means explains everything about the data. Still, at this point the analysis has reached a certain level of explanatory power by raising insights, questions and interlinking old topics in new ways in its aim of inviting people to see something differently. Painter Paul Gaurdner has said, “a painting is never finished—it simply stops in interesting places.” I regard the same thing to be true for qualitative research.

5.4 Ethical considerations and research integrity

Sensitivity to ethical conduct in human research in this thesis concerns the interviews from the first substudy. The Ethics Committee for Social and Human Sciences of the University of Eastern Finland was approached for a review of the plan of the whole thesis. The plan was accepted after its review. I shall address next how the three central principles of research ethics—informed consent, avoiding harm, and protecting privacy (see TENK 2019)—have been taken into consideration in relation to the study.

The aims and details of the study were disclosed before the interview to ensure that participation in the study was based on informed consent. This concerns both the interviewees and their institutions, because institutional permissions were acquired before the interviews. Both the interviewees and the institutions received a briefing letter about the study and an opportunity to ask further questions about it. It was also important that interviewees’ participation, as well as the right to refuse or discontinue participation, were equally available for the participants to choose in all phases of the study: before, during or after the interview.

Avoiding harm that participating in the research may cause to participants was considered mostly to be related to the privacy of their statements—in the wrong hands, the information given in the interview could potentially be misused or misinterpreted. I did not discuss any content of the other interviews with the interviewees to ensure this. The interviewees and the study’s location were also anonymized in the final report, because the interviewees could potentially be identified by location.

Data privacy was ensured by storing the interviews securely: the electronic data (audio interviews and transcribed text in Word documents) is protected with passwords, and paper data (transcription prints and consent forms) is in locked cabinets. All e-mail correspondence of the interviews was deleted.

In addition to the interview study’s ethical considerations, some reflection over how research integrity is taken into consideration in this thesis is in place. I have followed the practices of the research community in recording, presenting and evaluating the research results, as well as avoided plagiarism, falsification and fabrication of the results (see TENK 2012). However, a more intricate reflection on research integrity is needed here to discuss the potential of idiosyncrasy in the research results.

Qualitative analysis, due to its interpretive nature, potentially has more room for idiosyncrasy than quantitative analysis. It is to be expected, therefore, that in some way, my own assumptions, values and position in relation to the research topic flow into the analysis process and its results. Reflecting on research integrity in relation to this concern, I will first address the ways I have pursued to ensure the rigor of this qualitative research. These practices aim to minimize the effects of idiosyncrasy in pursuit of scientific objectivity. After this, as a way of enhancing the transparency of the research, I will reflect on how my own positioning to the research topic may have affected the research process.

The total avoidance of any idiosyncrasy may be an impossibility, but I have aimed to curtail its effects first of all by following and openly describing a rigorous iterative research process and, most importantly, the analysis steps in which I question my own interpretation and test the initial results with the data. The steps of the research limit the effect of a researcher’s intuitions that may drive the data analysis. I have additionally used data saturation—collecting data until topics start to repeat themselves and new findings no longer seem to arise—as a sign of having gathered enough material for a trustworthy analysis. I found this topical saturation in both the interviews as well as the written data. I refer here to a thematic saturation in which the key themes have clearly started to repeat themselves in the data. The point of saturation is based on my own consideration, not on a rigid methodological format. Naturally, this consideration of saturation also has potential for idiosyncrasy as well.

By publishing the results of my studies, I have ultimately subjected my work to naturalistic generalizability, the process in which the readers decide whether the findings resonate in them. This phase, which only occurs after the research is done, works as another way of keeping the idiosyncrasies of the research in check. Following Melrose (2010, 601), in the process of naturalistic generalization "readers can gauge how and in what ways the particular details and stories presented in case studies may be applicable to their own situations." In other words, the final test of the analysis lies in the hands of its readers.

Regarding my own position in relation to the topic of healthcare professionals and bioethics, it is important to note that while I am an outsider to healthcare institutions and professions, my interest and participation in bioethics practices have grown over the years of being a doctoral student. I have participated in efforts to inform both healthcare professionals and laypeople about bioethics topics, and I have been a founding member of a non-profit organization[10] that aims to strengthen the position of bioethics in Finland. Thus, I have been active in the kind of social and societal work that aspire to build prominence for bioethics as an academic discipline with both practical societal and institutional dimensions. I have found this educative work important to Finnish society, where bioethics is unheard of by most people, including most healthcare professionals.

Given this societal activity, one could ask whether my clear enthusiasm for bioethics compromises the research results in some way. I recognize that I hold a strong assumption that bioethics practices improve ethical consciousness and the ability to solve ethical dilemmas in the healthcare setting. One could say that there are both risks and benefits of being enthusiastic about one's research topic. For the most part, such enthusiasm offers a driving force for rigorous work; it has driven me to dig deep into questions that trouble me, since the questions speak to me not only academically but on a more

---

[10] The Finnish Institute of Bioethics, or Bioetiikan instituutti in Finnish.

personal level of curiosity. However, such a personal entanglement with the research topic exposes the research to biases and blind spots. Research is always limited as much as the person behind the research is limited, and it can be noted that my limitations likely go hand in hand with my enthusiasm. The scientific community, in the end, holds researchers accountable, and in this context, I am open to further debate and critical evaluation of my work.

6 Findings and insights from the substudies

I address each substudy in this chapter to discuss their findings and insights. The two empirical substudies are discussed in relation to the discourse found in the data. The third, non-empirical substudy takes a theoretically oriented position on the topic of moral expertise in the case of clinical ethics consultation. This theoretically driven, argumentative third publication ties together the empirical findings, because it builds toward an argument on the meaning of providing open social space for ethical dialogue in the healthcare setting.

6.1 The professional vision of clinical ethics consultation

The discourse analysis of the clinical ethics consultant (CEC) interviews generated two higher categories of discourse: **order** and **agency**. The discourses of order I identified—**managerial, emotional,** and **rational** order—refer to the kinds of discourse that shape the professional realm of inquiry in CEC practice. The discourses of agency, however, describe the ways in which the ethics consultants **act** in their professional role to solve problems in their professional domain. The discourses of agency I interpreted from data consist of **technique**, **exploration**, **deliberation**, and **distancing**. I also found a bridging discourse of **neutral interaction**, activated to level tensions concerning the ethicist's professional legitimation.

6.1.1 Discourses of order

What I have identified as the discourses of order shape the ethics consultants' professional domain. These are the realms in which the meanings of the professional practice arise, answering the question **why** clinical ethics consultation is done in the first place. Ethics consultation is called for when something—an ethical dilemma or a conflict—”bubbles up” in the hospital environment, in the words of one of the interviewees. Ethics consultants work toward rebuilding order when such a rupture of uncertainty is suddenly and unexpectedly confronted. I have identified three different kinds of order that are meaningful for the ethicists' realm of work.

The discourse of **managerial order** refers to work in which the CECs participate in the managerial life of the hospital. A modern hospital—a highly complex institution—needs to be managed socially, bureaucratically and economically. The CECs interviewed were hired by the hospital and held accountable to it, so it is natural that their work would partially be shaped by demands or aspirations to participate in the managerial life of the organization. One clear example of the managerial order in the data is using ethics consultation as a way to avoid lawsuits. Seen from this angle, ethics consultation becomes meaningful and legitimized by serving as a way to keep the hospital out of legal trouble. This also includes how an "ethical note in the record"—proof of ethics consultation—may help to defend the hospital staff, should they be sued.

The discourse of **emotional order** takes a turn into a very different realm in the CEC's professional domain and combines the kinds of work supporting hospital staff in ways that can loosely be defined under the category of "emotional." The aim of alleviating distress came up repeatedly. The discourse of emotional order constructs the emotions of the staff as a potential source of social disruption, and the ethicists, in turn, are agents whose interventions—such as ethics rounds—enable the doctors and nurses to repair the disruption in order to continue to do their work. This discourse constructs healthcare work as not "only work" in a technocratic, detached way, but rather as a mission that involves a deep form of emotional commitment and psychological absorption. The ethicist is defined as someone having an influence to work as a "vent" through which the emotional content can come out safely, again maintaining order in the hospital environment.

The third discourse of order, **rational order**, depicts the ethicist as capable of providing rational models that support and sustain ethical practices in the hospital life. The ethicist identifies ethically questionable situations and practices and transforms them into systematic policy, knowledge, and methods within this discursive frame. The discourse of rational order builds upon a vast Enlightenment idea that puts weight on reasoning, gathering evidence and questioning the status quo with the intention to enable progress. Everyday life is portrayed as muddy and confusing, and turning these ambiguous realities into policies and practices can “give light” to the overall healthcare practice (while the alternative is portrayed as darkness).

6.1.2 Discourses of agency

The discourses of order define the aims of the CEC practice, whereas the discourses of agency refer to the means by which order is pursued, answering the question of **how** clinical ethics consultation is done. I have identified four discourses of professional agency: technique, exploration, deliberation, and distancing.

The agency discourse of **technique** can best be defined with a toolbox metaphor: The ethicist is portrayed as being in possession of learned practical means that enable the work of a CEC. The toolbox can be transferred from one situation to another, and the tools can be identified as, for example, knowing the principles of healthcare ethics, understanding cultural and legal contexts, and having the skills and methods of facilitation and mediation at hand. The agency of technique constructs the work of the CEC as an expert territory.

Unlike the discourse of technique, the agency discourse of **exploration** arises from a place of uncertainty. The ethicist is seen as **not** having the answers and tools to solve all potential arising problems; rather, the CEC **explores** knowledge sources and learns from the others’ experiences. This can lead either to unexpected discoveries and success stories or to no results at all. Thus, the discourse of exploration abandons the idea of certainty that is silently embedded in the discourse of technique. The discourse of exploration was also invoked by the thought of “keeping moral space open” (interviewee quoting classic text by Walker 1993), referring to a role in which the ethicist is attuned to look for signs of something that she does not yet know about.

The third agency discourse I identified is the discourse of **deliberation**, which expands the sphere of the ethics work beyond the influence and agency of the individual clinical ethicist. The discourse of deliberation brings forth the idea that ethical questions are meaningfully encountered by a **group** of deliberators collectively constructing shared decisions and solutions. The discourse of deliberation, by stepping out of the individuality and agency of the ethicist herself, represents ethical concerns as political and thus, not appearing in the same "objective" way to all observers. The ethics work is also constructed as open to individual biases. This discourse exposes a hidden tension within the identified CEC discourses: where to draw a line between what needs to be deliberated and when to count on the individual ethicist's expertise.

The last agency discourse captures what I call **distancing**: the construction of a strategic outsider position. The ethicist positions herself within the discourse of distancing as detached from the social processes and interactions that have formed the conflict or problem at hand. The ethics consultant is depicted as wise enough to understand the big picture to know what is "really going on," aware of hidden implications and social dynamics. She is also respected and courageous enough to surface her insights about the situation, making people confront what is hidden. The social positioning as an outsider creates a distance that works as a valuable resource for the ethicist, because it holds great functional potential for reframing social situations to untangle problems and manage conflict.

6.1.3 Neutral interaction alleviates tensions

I also received many surprising explanations when interviewing the ethics consultants about why the CEC practice should generally be accepted rather than rejected. This was surprising mostly because I did not make accusations or doubt the validity of CEC practice as I approached the interviewees—on the contrary, I was quite openly excited about its potential and value. I realized the interviewees were not, in fact, arguing against any actual accusations happening in the conversation; rather, they appeared to be shadowboxing against something that is embedded in their profession and its environment. The deconstruction made in this study of the CEC discursive landscape offers some insight into why the CECs might feel a need to defend the legitimacy of their practice, because it entails some inner tensions if one looks at the discursive framework closely. Nowhere is this as clear as in the tension between deliberation and individual expertise, where it becomes evident that it is hard to define to what extent the ethicist should act as an individual expert and when collective efforts should be undertaken.

I found the tension in defining the limits of the ethicist's professional expertise alleviated by a discourse of **neutral interaction** claiming that the ethicist's role is, in fact, not to give an expert opinion at all. The discourse of neutral interaction constructs the legitimation of CEC practice as **consensus building**, framing the ethicist as the neutral party—an interaction expert in the pursuit of consent. Putting weight only on the **interactional domain** of the ethicist's work, however, renders the **moral-political domain** invisible and leaves undiscussed whether "ethics" implies and aligns with the pursuit of "consensus." It appears that the interaction domain of ethics work is easier to legitimize and validate, whereas the more politically charged, moral-ethical dimensions are more easily conflicted and can potentially even present a threat to the legitimation of the profession. My interpretation is that the difficulty in encountering the questions in the political domain leads to shadowboxing against the potential claims of illegitimacy I encountered. Evoking the bridging discourse that frames the ethicist simply as an interaction expert appears to alleviate these inner tensions. I shall return to these thoughts about the inner tensions and questions about the legitimation of clinical ethics consultation in my later substudy on the topic of moral expertise.

6.1.4 Conclusions and limitations of the study

The study brings forth a qualitative understanding of the intricate roles the CECs assume as they move within an array of social positions in their hospital work environment. The discursive landscape of both order and agency demonstrates the different end goals of the ethicist's work and maps out her forms of agency in pursuing those goals. Different kinds of expectations are held for the professionals, whether or not the goal is to sustain managerial, emotional or rational order, likely placing the ethicist in a social position loaded with built-in tension and ambiguity. The study makes some of these points of tension visible and suggests that the tensions are **built** into the profession, because the professional discourse lies between different ideological constructions: both collective and individual forms of agency and their different conceptions of order. The bridging discourse of neutral interaction can be invoked not only to alleviate some of the tensions but also to defend and legitimate the CEC practice against potential resistance.

The analysis made in this study raises questions for clinical ethics consultants to discuss. Can one of the goals—sustaining managerial, emotional or rational order—be named a priority to be handled in a situation when they might come into conflict? I hope that my study helps professionals conceptualize the choices they make in their work as they move flexibly between the different forms of order and agency by making this social reality more clearly observable and practical, something ready to be dealt with in open dialogues and conscious choices.

Regarding the study's limitations, given that it was conducted with a relatively small data set of 11 interviews and in only one urban area alone, it should be acknowledged that the study likely reflects a local culture. However, I do not see this as detrimental to the analysis, because my focus is on the stirring of imagination to view things in a new light by building a deeper understanding about the profession's social realities. A small set of interviews has allowed me to dig into the data more deeply, creating an intricate and deep, rather than an extensive and vast, understanding.

Another limitation concerns the nature of the data. The interviews present the profession as narratives and descriptions; therefore, they do not capture the ethicists "in action" in their process of fulfilling their roles and expectations. Including ethnographic field observation data would have deepened the understanding gained and allowed me to portray the ways in which the ethicists act in their "hands on" reality. However, the framework developed in this study can be useful for further research that could map out, with ethnographic data, how the discourses are lived through and translated into action.

6.2 Comparing medical ethics and nursing ethics in Finnish professional texts

The second substudy analyzing text data of Finnish medical ethics and nursing ethics explores the social constructions of professional ethics in the two professions side by side. I first address the codes of ethics and then move on to the analysis of the textbooks.

The codes of ethics of both professions were built around a list format, giving an instant impression of similarity. Both also state the same kinds of healthcare principles. However, paying closer attention to nuance brings out interesting choices of language, claims of authority, and different kinds of constructions of the professional sphere of influence. (See the appendix for both the translated and the original codes in Finnish.)

The medical code of ethics lists healthcare principles in the following order: beneficence, respect, justice, autonomy, nonmaleficence, and confidentiality. The structure apparently does not imply a priority order; yet advice how to deal with colliding principles or potential conflicts is not integrated into the code. The theme of **profession** appears forcefully throughout the code, with constructing ethical professionalism mostly occurring in two social domains: the doctor-patient relationship and the collegial network with other doctors. A position of authority is openly claimed and written out, and this position is constructed as something to be upheld: "By her behavior and action, the physician must uphold the honor and trust assigned to the profession and required by the nature of the work." (Physicians' code of ethics, section II, see Appendix 1.) Perhaps surprisingly, the rest of society does not appear very much in the code—it is only mentioned as a context for "giving testimonies and making statements (...) based on medical evaluation that yields objective observations," (Ibid., section IX) but not as a forum for dialogue, politics, or educating the public.

A significant difference between the two codes concerns the language used in reference to the patient. The medical ethics code strictly uses only the word **patient**, whereas the nursing code of ethics expands the language and refers to the people also as **individuals** and **human beings**. The aims of nursing are defined even more widely by broadening to lens to serving "individuals, families, and communities." (Nurses' code of ethics, section I, see Appendix 2.) Nursing is also presented as an effort to educate society and help the underprivileged: "She [the nurse] gives health related knowledge for the public and advances peoples' abilities to take care of themselves. The nurse collaborates with community services as well as disability and patient associations" (Ibid., section V). The nursing code of ethics also takes an interesting turn in comparison to the medical ethics code by constructing the nurse as an individual: the nurse is claimed to be “personally responsible for her work” (Ibid., section III). However, in addition to this, the nursing code also shows a collegial and collective form of agency in stating, “nurses working in the same care community together are responsible for the quality of the treatment and the constant advancement of this quality.” (Ibid.)

This short analysis of the codes of ethics show how the two professions’ ethical worldviews are constructed differently. The further analysis presented next delves deeper into these constructions.

6.2.1 Medical ethics discourse

Four discourses were discovered in the medical ethics guidebook: **universal ethics**, **biological and legalistic reductionism**, **non-subjectivity**, and **threat**. I will introduce each discourse here shortly. A more thorough analysis including illustrative data samples can be found in the substudy’s original publication.

Upon opening the medical ethics guidebook, one first comes across the modern Physician’s Oath. The Oath and further references to the ancient Hippocratic Oath appear as a concept that seems to hold an astonishingly watertight self-evidence throughout the text. As a side note, it should be added that often identifying the ”self-evidence” in the texts is a more muddied and complicated task, because the texts typically show ambiguous ways of approaching a topic. However, the concept of the Physician’s Oath as a unified, carved-in-stone mentality is one of the clearest, most crystallized examples of taken-for-granted discourses that I have ever come across in my studies so far. The ancient Hippocratic Oath is represented in this discourse as an eternal entity, packed with historical prestige and rhetorical vigor. I have identified this framing as the **discourse of universal ethics**, in which both the modern and the ancient oaths lay a foundation for the physicians’ ethics to appear as a self-standing concept, making the impression that the physicians’ ethics transcends time, culture, and the subjectivity of individual physicians. The modern Physician’s Oath is seen as giving doctors practical guidelines for daily work, constructing a view that a trained physician who has taken the Oath will also naturally be virtuous in her practice and able to apply the Oath into different situations. It is left undiscussed, however, why the ancient Hippocratic Oath is given such moral authority in defining the ethics of modern medicine, considering the changing of the times since—it is easy to assume that it would likely be inexplicable, or even frivolous, to refer to ancient times in many other contexts.

The discourse of **biological and legalistic reductionism** constructs physician's ethics in the form of either observing biological facts or following legal constraints and principles. I found the clearest example of biological reductionism in guidelines for limiting or withholding intensive care by representing this as a purely medically rational process. The scenario that a physician may come across a case of uncertainty is, however, acknowledged and guided to be resolved with a "fixed period care trial." However, guidelines for how to decide the length of the trial and what kinds of cases of uncertainty it may be used for is not included. The implication is that the doctor reading the guidebook is already in possession of this knowledge and does not need to be guided—decision making is shaped as a rational process without greater tensions.

Legalistic reductionism, though, represents another form of reductionism identified in the text; it frames **the law** as the source and justification of ethical conduct. Ethics is constructed as arising from the law within this discourse, and legislation serves to make the ethical standards appear as stable and taken for granted. The implication is that ethics is not (at least openly) treated as a value concept with social, historical and political fluidity and ambiguity. This legalistic framing may, interestingly, be at least partly in conflict with the discourse of universal ethics that holds the Hippocratic tradition to a similar status. The tension between the two discourses shows how discourse is always multidimensional and draws from several cultural constructions at once. Nevertheless, both discourses escape the positioning of ethics as a debatable and politically charged concept, constructing the nature of medical ethics as authoritative and rigid.

The discourse of non-subjectivity constructs the fading of the physician's subjectivity in the text. The tendency in the guidebook to frame ethical considerations with non-subjective language were already discovered in the discourses of universal ethics and reductionism, because the discourses shift the focus from individuals—their value realities and personal histories—toward universal values, highlighting a detached and unemotional tone. The discourse of non-subjectivity builds on these discourses, taking further a view on the physician as an individual that is fundamentally neutral and in control of her feelings. I subdivide the discourse of non-subjectivity into three topics: psychological absorption, controlled interaction with patients, and strong group membership with colleagues.

First, there is the requirement for psychological absorption that could be summed into the statement “first a physician, second a person.” Becoming a physician is framed as something more than simply a career—it is a duty and a life mission. Nevertheless, clear limits are proposed for this psychological absorption, because physicians are guided not to identify with their patients to avoid burnout. The physician’s emotions are represented as controllable because the doctor is constructed as actively being in control of her level of empathy. A view that the doctor will feel something about her work regardless of her professional control seems to be missing.

Second, controlling emotions is also mirrored in the doctor-patient relationship, because the doctor is represented as having agency to manage and control the encounter with the patient—who, in turn, is represented as a feeling subject with potential unpredictability.

The third topical area in which the physician’s subjectivity is faded is the context of collegial community, emphasizing the ideal of a united profession. Potential conflict between colleagues is taken up in the guidebook and framed as clearly negative: Disagreement between physicians is seen as deteriorating patients’ trust and the overall respect for the medical profession in society. Unlike in academic science, struggle and argumentation are, interestingly, constructed as taking the profession backward rather than forward. In relation to this understanding of deteriorating trust, patients are portrayed as passive, unable to take professional disagreement and the uncertainty of medical knowledge into account when making interpretations about their own situation and treatment. Additionally, by avoiding conflict between colleagues, a physician’s status is seen as something that is consciously **upheld** by acting in certain ways, rather than **received**. Respectable status, thus, appears as constructed through control and not as something that may or may not happen as a consequence.

The idea of upholding status was also echoed in the last identified discourse, **the discourse of threat**, which constructs the medical profession as threatened, as a vulnerable group needing to protect itself. Threat is seen arising from multiple channels at once: modern changes to the profession itself (its wide subspecialization created by the increase of scientific knowledge), changes in its position in society (the move from insular professional autonomy toward societal regulation), and changes in the overall culture (attitudes shifting toward further individualism). A silent claim of resistance against changes in the profession and in society is made in this discourse, suggesting the **true authenticity** of the medical profession to be qualitatively something other than what the modern changes and adaptations require physicians to be.

The discourse of threat is entangled in the text in the topic of patients' **trust** in physicians, making the claim that **the autonomy of the profession** is the source of patients' trust. This trust is represented as being crumbed by societal influences that restrict the profession's "independence, elbow room, and decision making power." Laws and procedures are thereby framed as weakening, not strengthening, the public's trust (the opposite of what an outsider might assume). The potential risks of putting physicians in powerful positions with total professional autonomy without regulation are left undiscussed.

A side effect of strongly emphasizing professional autonomy is the assumption that the medical profession itself is the true source of ethical understanding, the rest of society having little to offer in this regard. Outside influence is framed as something that has significance only **in addition** to the body of medical ethics **rather than as a part** of it. This kind of discourse builds a silent "us and them" positioning, obscuring the vision that society and the medical profession can also be seen as having a shared mission. The discursive gap between physicians and society widens ever more, because societal influence is also constructed as **crumbling the trust** of patients.

6.2.2 Nursing ethics discourse

Nursing ethics, in contrast to medical ethics, constructs a different view, highlighting context, a nurse's subjectivity and reflectivity in its focus. The discourses identified are **local ethics**, **enlightenment**, and **moral agency**.

The first identified discourse is the **discourse of local ethics** that constructs ethics as a localized contextual matter, implying that ethics may be perceived differently in different contexts. The nurse is directed to be actively aware of her local ethical context. Seeing ethics as localized in this way is constructed as occurring in different social spheres at once: team, organization, society, and even in the nurse herself. The key to ethics is seen to be the nurse's awareness and reflectivity. Additionally, it is natural that ethics is seen in a way that constructs **change** as a possibility, because ethics as so constructed is bound to people and contexts. The silent push toward change can be speculated to hide a seed of discontent about how things are now.

The discourse of enlightenment, the second discourse identified, produces ethics as a topic to be cultivated through research, education, and developmental efforts. The subject of ethics is constructed as a growing body of knowledge, with science as its backbone providing a form for process and authoritative validation. Rationality (meaning theory, analysis and scientific method), through which ethics can be developed and evaluated, is placed at the center of the discourse. A concern that reality may **not** be in tune with ideals is presented for open questioning and study, posing the question whether the ethical climate and the working environment align with shared ethical standards and principles. A position of objective analysis is constructed, stepping out of the everyday working life and its social scene with the intention to examine it in a more detached and systematic manner. The ethical climate and cultures of care communities are subjected to research, and even ethical guidelines themselves are constructed as an object of research, analysis, and critique within the framing of the enlightenment discourse. The subtext is that nurses and clinical communities may be acting unethically without realizing it themselves, because they are seen as potentially subject to blind spots that can be surfaced with closer scrutiny. The narrative holds that blind spots that have first been identified can then be confronted with efforts to develop the ethical competence of both individuals and the ethical climate of clinical communities.

The discourse of enlightenment also appears in the nursing ethics text as research references, reflecting an academic rather than a practical tone. In comparison to the medical ethics guidebook that mainly refers to tradition, professional cohesion and consensus as legitimation, and lists readings as a voluntary addition, the nursing ethics text clearly leans toward academic resources in the legitimation of its arguments. It can be speculated whether this reflects a power asymmetry between the professions: Medicine appears to take the legitimation of its own tradition and professional position for granted as a basis for making arguments, whereas the nursing text goes through a strenuous effort of referring to academic studies in its aim to convince readers. I shall address later in the discussion the findings that this may also reflect the fact that the two texts have different kinds of professional origins.

The final discourse identified is **moral agency,** the construction of the nurse as an active moral agent in her work environment. The preceding discourses construct ethics as something that can be changed and something both to be aware of and to scrutinize; the discourse of moral agency builds on this and creates a subjective action position, proposing that the nurse has an inner moral compass guiding her professional action. This discourse is emancipatory, depicting the nurse as an active voice, not as a victim of circumstances.

The discourse of moral agency constructs both an inward and an outward dimension of action: the nurse examining and being aware of and in dialogue with her own moral intuition (inward agency) and with the courage to actively voice her moral views (outward agency). The nurse's lifeworld is constructed as deeply intertwined with her work when the moral agency is seen from the inward dimension, even to a point that her mental health may be at stake if the work environment appears in conflict with her moral compass (experiencing moral distress that may lead to burnout or anxiety). The outward dimension highlights courage as a central virtue: The nurse is guided to be courageous enough to voice her concerns and moral intuition to physicians. Needing to have **courage** to talk about ethics with physicians silently points toward a working culture in which such action is, interestingly, not expected. The discourse of moral agency empowers the individual nurse to be courageous and to speak out her mind, yet the question should be posed about whether such a discourse in fact disempowers nurses as a professional group. This is because it constructs the problems with interprofessional dialogue as an element of individual courage and moral agency rather than criticizing the kind of hierarchies, structures and traditions of work that create barriers for interprofessional communication in the first place.

6.2.3 Conclusions and limitations of the study

The analysis summarized brings out vastly different kinds of realities for understanding ethical professionalism in clinical contexts: Medicine constructs a culture of objective neutrality, universality, and strong group membership, whereas nursing constructs ethics in terms of changing situational variables, scientific efforts, and subjective agency. The analysis brings out fundamental differences in ethical worldviews between the two professions and their moral traditions. It also points to how widely different healthcare principles can be interpreted, depending on the interpreter's professional identity and agency. I have also lightly touched during the analysis upon questions of professional power and the potential points of tension and struggle. My intention has not been to agitate interprofessional conflict but to bring meaningful differences and tensions into view to create in-depth understanding. My intention is to consider, further on, potential pathways for enhancing interprofessional communication, with bioethics in mind.

Concerning the limitations of the study, attention should be pointed toward the differences between the two texts in terms of their origins. The physician's ethics guidebook (its 7th updated edition) is the result of committee dialogues and represents a canonical view of the profession. The nursing guidebook, in turn, is part of a yearly series of different themes; thus, it does not represent a canonical view but is simply a collection of writings. A strict reader would, thereby, comment that the two books are not commensurate for juxtaposition. However, because a similar, committee-made ethics guidebook **does not exist** for nursing, I, as a researcher, am left with what **does** exist. Perhaps the differences between the origins of the books reflect, once again, the underlying differences between the two professions—their cultures and traditions for organizing the profession and producing knowledge. I therefore found it important to study the two cultures regardless of, and even especially because of, their differences. Constructing the two books as research data regardless of how they were produced is a theory-driven process guided by my research questions and is methodologically in tune with the CDA theory. Constructing an object of research for discourse analysis can be done in a transdisciplinary way, combining relevant categories and theories as long as the research questions stay cogent, coherent, and researchable (Fairclough 2010, 5).

Another limitation concerns the fact that paying attention to certain parts of the texts naturally eclipses some other content in the data and does not necessarily do justice to the texts in their entirety. Additionally, analyzing texts instead of ongoing, natural professional action is naturally a limitation because it does not capture moral decision making and the navigation of sensitive situations in action. It should also be noted that texts can be somewhat random by nature, depending on who has written them. Texts also tend to produce reality in ways that are not as “messy” as the real world; thus, they do not capture everyday ethical considerations and action very realistically. Overall, a conceptual detachment of the everyday ethics of professionals from the writings in professional ethics texts should be kept in mind while reading the study (see Abbott 1983, 857).

Despite its limitations, the study’s findings point to a cultural gap between the ethics of medicine and the ethics of nursing. This study brings attention to how shared ethical principles surprisingly may not, upon deeper scrutiny, imply shared ethical worldviews after all. The inevitable question that arises is whether crossing the silos of professional and disciplinary ethics is a necessary quality in the healthcare setting—and if it is, should the bridges be crossed? Can they be crossed? Finnish healthcare has not been keen to adapt bioethics models to advance ethical discussions unlike many other—including Nordic—countries, but the question remains whether it should.

6.3 Defining the paradox of moral expertise

I take a perspective in the final substudy on the contestable concept of **moral expertise** in the context of clinical ethics consultation. The debate over whether clinical ethics consultants (CECs) have moral expertise or not has been heated for decades, centering around questions of whether moral expertise is generally possible at all—and if it is, in what ways should the CECs prove it (see, for example, Noble et al. 1982; Crosthwaite 1995; Shalit 1997; Yoder 1998; Archard 2011; Gordon 2014; Cross 2015; Iltis & Rasmussen 2016). The typical logic of the debate holds that if CECs are to claim their professional domain as valuable and worthwhile, the profession should be based on a clear and recognizable form of expertise. The underlying message in this argumentation is that if such a proven expertise cannot be identified to be possessed by the consultants, the practice of clinical ethics consultation hangs in the balance.

6.3.1 Framing the paradox

Arguing "for" and "against" moral expertise is an intellectually important debate for academics, yet I suggest that it leads to a paralyzing contradiction for practicing professionals. Ethics consultants continue facilitating ethical dialogues when moral expertise is accepted; the relevance of CECs creating an open social space for value discussions suddenly diminishes when moral expertise is rejected. I argue that this conceptual dichotomy surrounding moral expertise indicates an all-or-nothing approach that categorically misses the point of why fostering social space for moral discussions in the healthcare setting matters.

Considering the topic of moral expertise as **an unresolvable paradox** is a potential answer I envision as a third way to approach the problem of defining that legitimating moral expertise in CEC practice. Maintaining that the concept of moral expertise can be both defended and rejected with rational reasons, I claim that moral dialogue nevertheless holds its purpose for healthcare, regardless of whether CECs are accepted as moral experts. Therefore, I reframe the debate of CEC's moral expertise by suggesting that the legitimation of clinical ethics consultation does not lie in the legitimation of moral expertise, but instead, in the **meaningfulness and intrinsic value of creating a constructive forum for ethics**—a place of dialogue—that ensures that moral discussions will occur. My views are theoretically based on Chantal Mouffe's (2005 & 2013) political theory of **agonistics** and her concept of the **democratic paradox**. Mouffe, in short, constructs a theory of political order that depicts the ineradicability of antagonisms in a pluralistic, democratic society. She claims that value divisions are solid and real, and they should not be watered down by putting too much weight on consensus. Mouffe sees the struggle of values and worldviews as a goal in itself that should be embraced rather than overrun by consensus (Ibid.).

Based on the previous substudy on the professional vision of CECs, I claim that the paradox of moral expertise in clinical ethics consultation stems from the two different constructions that belong to the very ethos of the profession: **value pluralism** and **expertise**. Value pluralism holds that everybody is seen as being entitled to their worldviews, having the right to make healthcare decisions based on personal views about life, death, quality of life, deity, and so forth. Expertise, conversely, holds that experts hold a central role in fostering decision making and maintaining harmony and social order.

I do not deny the value and importance of both of these basic tenets of the profession; however, a tension between inclusion and exclusion can be identified when they are more closely scrutinized. Pluralism acknowledges the lack of objective view on morality and therefore holds that the struggle over worldviews will never be closed, whereas the idea of expertise presupposes that experts have tools and knowledge to shape the discussion.

6.3.2 Consensus and the neutrality rhetoric: A critical perspective

The paradoxical nature of the profession may raise social pressure against the professional legitimation of CECs, so I will argue next why the paradoxical nature of the profession should, nevertheless, not be avoided and denied.

I discovered the bridging discourse of neutral interaction in the previous study of CECs, framing the CEC practice as simply "neutral" mediation work. This discourse appears to avoid the paradox by claiming that the work of CECs is not about moral expertise at all; instead, it is about building consensus and allowing neutral interaction. This kind of argument naturally eases social pressure, but when scrutinized closely it may damage the profession's ethos by denying **both** tenets at heart of the profession: expertise and pluralism. First, framing ethics consultation as only mediation means making a silent claim that expertise in **ethics** is actually irrelevant for the profession—therefore denying (ethics) expertise. Second, it suggests that consensus can be built anywhere through the right kind of process, suggesting that the pluralism and the division of values is, in fact, **not** comprehensive and real, framing ethics consultants as social architects of consensus.

This kind of consensus rhetoric therefore denies pluralism by **silencing the struggle of values** that is the very essence of pluralism. Putting weight on consent, therefore, silently suggests the CECs are in control of value divisions and can limit the antagonisms that follow (cf. Mouffe 2005 & 2013). The consensus rhetoric may ease the tensions created by the paradoxical nature of the profession, yet, surprisingly, it may do more harm by silently watering down the whole essence of being an **ethicist** rather than a **mediator**. Therefore, I claim that putting too much weight on consensus as a professional ideal may be detrimental to the fostering of pluralistic, open moral conversations.

My critique of aiming for consensus is based on a post-structuralist and constructionist understanding of power that views power as constituting the very identities that people bring to the negotiation table (for the philosophical and theoretical basis of this view, see Foucault 1995 & 1998; Rabinow 1984). Institutional roles shape identities, provide agendas, reproduce forms of social hierarchy, and create social distance between people (Cribb & Gewirtz 2015, 4). From this perspective, it is not insignificant whether one happens to sit at the negotiation table as a patient, an ethicist, a nurse, or a physician. Power is diffused in the discourse and knowledge, and it shapes what counts as sayable and thinkable in the hospital meeting rooms. It is a product of dynamic social action, manifesting through professional roles and shaped in public discourse such as science, media, and education.

Therefore, constituting the negotiation as simply "neutral" and constructing the identities of the negotiators as having equal starting points means, in fact, turning a blind eye to power. The consensus rhetoric thereby creates an invisible smokescreen that hides the power structures that manifest in deliberation. According to Mouffe (2005, 22), it “disguises the necessary frontiers and forms of exclusion behind the pretenses of ‘neutrality’.” This is because claiming the process and its results as a consensus not only hides the workings of power, but it also makes open resistance practically impossible, because the claim of reaching a pure, rational consensus silently illegitimates any forms of challenge to it (cf. ibid., 32).

Diffused power and the structures of knowledge can never be erased from institutional transactions nor should they be. Power and institutional agency can both destruct and construct, depending on how they are used. The use and existence of power is not, thus, the object of my criticism; the idea of consensus building is. It is clear that while consensus is shaped through discourse that is further shaped by power relations, it always entails some forms of exclusion: Not all propositions can be established in the consensus, but solutions arise out of a **struggle** between arguments. Nevertheless, the consensus rhetoric **renders the struggle invisible**. It means disregarding the idea that the very condition of ethics consultation is making pluralism visible and negotiable. CECs are, however, at a special vantage point with power to create open space for value discussions. They are in a strategic position to make a space for voices that other institutional processes would otherwise simply suppress but only if they use this power mindfully, keeping an eye out for marginal voices without watering them down with consensus.

This critique no doubt sounds harsh, and I want to highlight that I do not claim that consensus would not be socially desirable and extremely relevant for managing difficult situations. The CEC who can move between different worldviews while maintaining a peaceful atmosphere and finding a solution that pleases all parties does work that is no doubt invaluable and helpful for the daily hospital life. Nevertheless, it is important to distinguish between consensus as a professional ideal and consensus as a daily necessity. This paper has looked at the distance of the former category without making practical suggestions for the latter. However, I realize that distancing professional ideals from everyday professional life is a problematic endeavor, because it does not solve practical questions concerning how to deal with social pressure and push for consent without watering down the ideas of pluralism and expertise in the described ways.

6.3.3 Embracing the struggle: Keeping moral space open for pluralism

Returning to the post-structuralist understanding of power, the views I take are based on the idea that moral expertise in the healthcare environment is not, in fact, reserved for clinical ethics consultants. The deeper question is not whether CECs can legitimate their expertise position but, rather, whether they can challenge the more traditional and subtle forms of "moral expertise"—the institutionally hegemonized forms of moral authority that distort rather than divulge their claims of moral expertise. It is obvious that before clinical ethics consultants ever stepped into the picture, indirect and invisible forms of moral authority were indeed already in place, such as conceptions of right and wrong deeply knit into the physician's profession, and hospital institutions' structures for authority and decision making (Freidson 1986 & 1988; Rosenberg 1999; Rothman 1991). Neverthless, this kind of moral expertise is elusive and difficult to pin down because its expressions are not explicit but rather normalized into the existing conditions, traditions, hierarchies and structures of authority. They are simply "there," escaping open confrontations.

The difference between CECs as moral experts and the traditional, subtle forms of moral authority is simply that a CEC makes the questions open for dispute and argumentation. This, no doubt, subjects CECs to constant criticism. However, this openness to moral claims contains a remarkably important seed of wisdom. Making moral questions **an open and not an implicit struggle** means acknowledging that value questions are **always** a part of healthcare. It means acknowledging and providing social space—breathing room—for value discussions to occur in a healthcare world that is otherwise typically defined in economical, technical, and narrow professional terms. Insofar as moral questions are not faced as an object of open and ongoing conversation, it is more likely that powerful people and institutions use their moral authority to construct certain versions of ethics without any open challenge. With this view I hold that the marker of an unhealthy, morally closed healthcare system is the disappearance of dissenting voices and values into hidden margins, not the open conflict between different views.

Understanding that healthcare needs open forums so that values can surface themselves, it is easy to see why CECs provide a vital agency to ensure that the moral space is kept open in the healthcare environment. CECs are constantly caught in the processes of struggle, and the point I am making is that **the struggle of values should not be closed, because it ensures a healthy moral climate that creates space for pluralism and debate**. Nevertheless, ethics consultants are a part of the struggle, as they are inside it, not above it. Therefore, the important arguments made by many critics of the CEC practice should be taken seriously: CECs should not attempt to raise themselves into a position of absolute moral authority. My view is that CECs can and should **strive** to become moral experts if moral expertise implies a legitimation of moral authority, but they should never reach such a position so as to **become** such experts. A position like this means staying sensitive and reflective about the concept of moral expertise and the potential danger for gaining social control that it entails. Moral expertise holds an ideal to be pursued but not achieved, as it is impossible to reach because its very essence is self-contradictory—a conceptual impossibility, a paradox (cf. Mouffe 2005, 137).

Based on these thoughts of the nature of moral expertise, I conclude with the vision that the CECs' role is not to legitimate a position of moral authority but rather to construct a social space for "a kind of interaction that invites something to happen, something which renders authority more self-conscious and responsibility clearer" (Walker 1993, 33). This role comes at the price of CECs themselves staying sensitive to their own professional claims of moral authority and accepting, even embracing, its paradoxical nature. Real alternatives must be at stake in order to expand pluralistic and open-ended horizons for healthcare ethics as an option to the more traditional, profession-based healthcare ethos. The alternative, in my view, is the open recognition of values in the modern healthcare field, casting light on the hegemonies and existing policies, practices and decision-making structures by creating space for a process of ethical consciousness that is conducive to a broad acknowledgment of pluralism.

7 Discussion

The process of this thesis could be described as standing in a room with multiple doorways, where the room symbolizes ethics in healthcare as an overall theme. The doorways facing the room symbolize the different professional worlds, their professional worldviews and identities entangled in the topic. My role as a social science researcher has been to open the doors and take a glimpse into each world. As a result, I have studied three empirical professional perspectives and taken one theory-driven perspective on the topic of moral expertise. Each of the substudies reflect an open-ended inquiry with a reflective (rather than objective) edge, with a focus on understanding as well as differentiating professional worldviews that look very much alike. I bring the separate findings and insights together in this final chapter to discuss the bigger picture of the thesis, closing the thesis with an understanding of uncertainty and the meaning of dialogue.

7.1 Mapping the discursive landscape of moral uncertainty in healthcare

This thesis started out with the formative idea that moral uncertainty exists in healthcare—whether it is evident on the surface or not—and that each profession I study holds a professional ethical worldview that construes an approach and position in relation to this uncertainty. I worked with qualitative data utilizing the theory of critical discourse analysis to expose these differences, bring to light their hidden assumptions, and bring them side by side in this thesis. Now, it is time to conclude what the discourse studies reveal about the constructions of these professions in terms of moral uncertainty.

The first study with clinical ethics consultants revealed that the consultants work on uncertainties as they “bubble up” in the hospital community. The CEC approach to healthcare ethics seems to be comparable to firemen putting out fires: a problem emerges in the field and prompts the CEC to work. Without the fire, the CEC seems to have no agenda, no focus for her expertise (consider, for example, how different this is to scientific work in which the researcher creates her focus by constructing research questions and then utilizing expertise to solve them). The identified discourses shaping the CEC practice show how the profession has constructed a discourse that marks the ethical uncertainties as graspable, solvable and actionable. The CECs, thus, seem to have a very pragmatic and action-oriented understanding about uncertainty in healthcare.

The second substudy, consisting of the analysis of both medical ethics and nursing ethics in professional ethics texts, showed great differences in the ways the two professions approach their moral uncertainties. The analysis of medical ethics exposed a rigid and universalized understanding of ethics. The physician's subjectivity faded to the background and interprofessional conflicts were resisted. The results paint a picture of historically unchanging ethics, an astonishingly wide contrast to the fast-paced development of the medical science. Viewed from the surface, one can even gain the picture that moral uncertainty does not exist in medicine; rather, laws, history, and the virtuous, non-subjective conduct of individual physicians ensure its disappearance. Thus, the observation can be made that the medical ethics discourse embedded in the Finnish professional texts render moral uncertainty in healthcare if not fully, at least to some extent, invisible. This can be derived from the construction of a powerful top-down view that portrays ethics as profoundly (if not completely) unproblematic and straightforward. Nevertheless, it is important to note that the discourses identified are not total in the sense that they would suffocate all other discourse.

Having neither studied medical practice in action nor interviewed medical professionals for this study, it should not be assumed that this kind of invisibility of uncertainty would be a quality of anything other than the professional texts. It is reasonable to believe that in comparison to the textbook, the everyday discourse circulated by the practicing professionals would leave more room for uncertainty. However, the textbook discourse portrays a view that has been collegially accepted and deliberated; therefore, the texts can be thought to express at least professional ideals in the abstract. This is important because what a profession values as its ideals is a key part of its discursive construction that must have at least some influence on everyday professional practice, even if these two constructions did not entirely match.

The nursing ethics texts were discovered to construct a widely different construction of uncertainty, one in which considerations of ethics appear to be constantly on the nurse's agenda. Uncertainty is constructed to be managed and confronted both by personal reflections and scientific inquiries. Uncertainty is, however, not constructed as being fully controlled by the nurse because it is expressed that a nurse may experience such a conflict between her values and her work that her mental health may be at stake. The nurse is seen as a feeling subject connected both to the surroundings of her work environment and task as well as to as her inner values and lifeworld. However, while the nursing ethics discourse constructs some emancipatory dimensions (such as moral courage) and an openness toward change that reflects a dissatisfaction with how things are now, the discourse remains, at least openly, uncritical toward its counterpart, the medical ethics discourse.

The discursive studies bring forward the insight that there appears to be no solid, shared language of uncertainty in healthcare. Healthcare ethics consist of a variety of discursive constructions tied to different professional roots and value orientations, not to forget constructions of professional authority and power. However, my intention is not to evaluate these differences as opposite poles in tension, as if to suggest they are mutually exclusive. Rather, my aim is to enhance critical consciousness of these differences. It should not be assumed that people were aware of these discourses in their own practice, because the discourses are culturally deeply naturalized into the "common sense" of everyday life. Therefore, critical studies like these open a new horizon to the existing realities, seeing them more conceptually and solidly.

This thesis was set to have both hermeneutic and emancipatory knowledge interests: I wanted to understand the professionals' ethical worldviews and their differences as well as to open conversation and consciousness about the abiding power structures. Some attention should be paid at this point to the findings from the emancipatory viewpoint. The results of studying the professional texts within the Finnish context raised questions about the ways that professional power was distributed in the discourse. Medical ethics takes a strong authoritative viewpoint, whereas nursing ethics makes space for this authority by remaining (at least openly) uncritical of it by highlighting subjective emancipation, such as courage, as a way to create more power and space for the nurse's ethical views to come forward.

This discursive struggle over power points attention to how power struggles between professionals are at play in the topic of professional ethics (whether this struggle is open or not). A continuum that portrays two ends, professional struggle over power on the other, and interprofessional teamwork in the other, can be delineated within the topic of healthcare ethics. This continuum reflects dimensions of negotiating professional power on one end—such as decision-making power and power over framing what counts as ethical issues—and altruistic goals of working together for the patients' benefit on the other. Claiming that ethics would only portray one of these ends would not be beneficial, because it seems reasonable to say that assuming healthcare professionals only having their own interests at stake would be paranoid, while suggesting that they simply have purely shared and altruistic goals would, in turn, be naïve. Thus, I suggest a way to examine healthcare ethics as a function that is on a continuum between those two ends. The way we organize healthcare practices and the ways in which we actively construct discourse on healthcare ethics influence our position on the continuum. It comes down to whether society encourages us to espouse interprofessional actions and dialogue or refrain from them.

Healthcare will probably always entail this kind of conflict: Some kind of professional struggle as well as interprofessional connection and mutual goals for the patient's benefit are both in the air simultaneously. It is difficult, if not impossible, to address moral uncertainty together while attempting to be completely "clean" of the politics of distributing claims of expertise. However, being aware that both of these realities exist on a continuum can open possibilities to build systems that support interprofessional work that is, after all, in the patients' and society's interests. My intention is, thus, not to close the struggle as to suggest it would eventually be solved; rather, I suggest ways to work toward enhancing the interprofessional end of the continuum.

I shall next argue for my view that an open recognition of moral uncertainty and the creation of opportunities for interprofessional moral dialogue can offer some possibilities for taking steps on this path.

7.2 Toward open recognition of moral uncertainty in healthcare

The inevitability of moral uncertainty in healthcare is entangled with patient care. It is the central building block for confronting the patient and her vulnerability in an ethically sensitive and sustainable way. And yet: the findings of this thesis point toward observing that there is no common language of uncertainty. It also seems that uncertainty is not necessarily commonly defined as the very focal point of healthcare ethics. In fact, it is often represented as an unwanted side effect of cases in which people find themselves facing conflicting principles or discordant opinions. Even worse, uncertainty sometimes appears to be silently denied altogether, implying that it is controlled by force of tradition, law, or technical expertise.

I am ending the thesis with the same thought I started it with: uncertainty exists. My studies have delved into a number of professional discourses that point to different ways of dealing with uncertainty, making it understandable, graspable and tangible for professional action, showing the multitude and diversity of social construction that surrounds it. Based on these conclusions, perhaps one could say that my research has come to no end at all; yet, it is only by exploring uncertainty that one can grasp it and make it visible. Only by understanding the professional discourse that constructs the ways we deal with uncertainty can we truly come to terms with it and comprehend it. Returning to T.S. Eliot’s words quoted in the introduction, we truly are back in the same place we started in but are seeing it anew—as if for the first time.

As stated, uncertainty often (even though not always) appears to be constructed as an unwanted burden, a side effect, a dimension of undesirable circumstances. I wonder if is it possible to turn this construction upside down: Can we look at moral uncertainty as the stable variable, while depicting principles, professional views and guidelines as changing? How would the mindset shift if uncertainty was moved from the margins to the center, from seeing it as the problem to understanding it as the very core of ethical healthcare—and seeing the recognition of uncertainty as the very confirmation that ethical ideals are being kept alive?

Based on my findings, I claim that understanding and acknowledging the **permanence of moral uncertainty in healthcare** invites a fresh (if not entirely new) approach to healthcare ethics. Viewing uncertainty in this way presumes a kind of humility and a natural sense of collaboration in which each stakeholder—such as a physician or a nurse—could bring their uncertainty into the focus of a mutual inquiry. The openness of uncertainty as a basic element of healthcare creates a position for each party to pose an open-ended moral question, saying, "I do not know the answer to what is bothering me, but I want us to explore this question together." Doing this enables moral uncertainty to be collectively recognized as something that can be confronted and solved through dialogue, a meaningful social process. My understanding is that fostering an environment in which moral dialogue has a place at the grassroots level of healthcare would both enhance interprofessional communication and collaboration and guarantee that professionals are doing their best to ensure that patients are treated humanely and compassionately.

Based on these thoughts, I want to end my studies with an understanding of the power of dialogue. As a social psychologist, returning to the concept of dialogue means that I have come full circle: I became interested in bioethics because of its promise to enhance dialogue between people coming from different roles and disciplines. Having now come to the other end of the research journey, I can offer my own perspective for why dialogue matters, based on what I have come to understand.

7.3 The case for moral dialogue

Finnish healthcare has not adopted bioethics practices in similar ways initiated elsewhere—from the U.S. all the way across Europe including many of our Nordic neighboring countries—but the question remains whether it should. Why should clinical bioethics practices matter to Finland? What is their value and why? I argue in this chapter that by building on an understanding of the permanence of uncertainty, the value of implementing bioethics in hospital settings lies in the meaning and power of dialogue, and because dialogue matters in general, it also matters in Finland. Therefore, my arguments are not focused on Finland alone, even though the lack of such practices in Finnish healthcare is my primary concern. I introduce six arguments in the following subchapters on why I view dialogue as a meaningful and beneficial practice for confronting and solving moral uncertainties in modern healthcare.[11]

7.3.1 Constructing moral space

The key aspect for dialogue, first and foremost, is the setting of a discursive space for people to come together. Logically, a play cannot start before the stage is set. This means providing the very basic elements for inviting a conversation to happen—the basic minimum involving the appropriate people, a room, and a topic. This sounds simple enough, but it does not come together without an intentional structure that allows the space to be formed. Structures for clinical bioethics—like bioethics committees, ethics rounds, or ethics support—represent the stage set. The actors in the play are the people involved in the case and whoever beyond the case appear meaningful for the conversation. For example, an ethicist or facilitator also takes a role in the play in moral case deliberation (Molewijk et al. 2008) or bioethics mediation (Dubler & Liebmann 2011).

Setting the stage may sound like the easiest part, but practical wisdom knows it is the trickiest. The most common objection heard from healthcare professionals is that they do not have the **time** to meet up and have value conversations. Time, without a doubt, is a limited resource. On top of the basic mission of helping patients get well, healthcare communities are typically stretched thin by demands of financial efficiency, bureaucratic

---

[11] The scope of the thesis is limited, so the questions of how the dialogue should be structured and on what kinds of philosophical understandings it should be based are not addressed here. However, it should be kept in mind that the question of **how** to organize dialogue arises after the reasons for **why** are established. I am arguing solely the ”why”-perspective. However, interesting writings on both the practical and philosophical dimensions to the ”how”-question of organizing dialogue can be found, for example, in Abma 2019; Kessels 2001; Widdershoven & Molewijk 2010.

tasks, and other organizational duties. However, as with all limited resources, the problem about time boils down to what is valued in an organization. The appropriate time will follow if moral dialogue is seen as one of the key priorities.

I continue from the argument about open moral space in the third substudy on moral expertise. Discursive spaces that allow moral dialogue to happen **invite** people to have a voice in values. It should be noted that we silently **approve** a closed moral space when we do not construct an open moral space. This is because it is **inevitable that value questions in healthcare are decided somewhere**: if not with open dialogue, then behind closed doors or—even more dangerously—silently, in-between the lines. The question arises about whether decisions are made justly and responsibly without open and transparent structures: If they are made in a just and responsible manner, additional openness and transparency would only enhance their legitimation and further help the people involved to commit to what has been decided. If they are not, openness would help the communities to make better decisions in the future. Whatever the situation, my claim is that enclosing value decisions in nontransparent black boxes is not good enough for modern healthcare. Structures that support moral dialogue are just like democracy in many ways: sometimes dysfunctional and even frightful, but undoubtedly essential and intrinsically valuable.

7.3.2 Enhancing responsibility

These thoughts of understanding the nature of dialogue as similar to the nature of democracy brings us to the topic of power. I understand dialogue as a way of providing a due diligence process for the powerful: “checks and balances,” so to speak. I do not refer by this to actual separation of power but rather to enabling transparency and exposure to others’ value considerations to support professionals in fulfilling their duties of responsible conduct.

Consider a typical case in which a physician is faced with having to make the decision whether to forgo life-sustaining treatment for a patient[12] (similar

---

[12] In Finland, physicians have the final authority to make this kind of end-of-life decision. This differs greatly from the U.S., where typically the patient’s family would hold the primary responsibility.

to what was imagined in the opening chapter). Imagine the prospect is that the doctor knows that the patient would be severely disabled if she were to survive. Now, put yourself in this physician's shoes and ask yourself: What kind of view do you hold about living one's life as a disabled person? This is important, because when making a decision like this, it is only natural that the physician's own conception of what it would mean for the patient to live such a life in the future will influence how she decides. A physician who has a disabled child may see the prospects differently compared to someone who does not. Whatever the case, if not exposed to other people's value conceptions and considerations, the decision is at risk of being made in a value vacuum. This idea has nothing to do with how good the doctor is in her medical practice; it is, rather, a comment that making decisions alone or perhaps with one or two like-minded colleagues is not an optimal condition for allowing conscientious and thorough moral considerations.

Social structures such as organizing moral case deliberations enable a space for open moral dialogue that would help physicians discuss their thoughts on the case. Talking with others from diverse professional views and life experiences would likely make a difference in a physician's decision making. Perhaps having had a considerate and multifaceted conversation with others would even help the doctor feel more confident in and responsible for the decisions made (cf. Walker 1993, 33). However, the emphasis is on responsibility in terms of providing checks and balances on power. Sharing considerations of the case with other people in a conversation allows transparency, because the decision-making process is visible for the other people involved. This enables different kinds of perspectives to be considered and creates more options, allowing the decision makers to see the nuances and understand the depth of values when considering the case. Moral dialogue thus sharpens responsibility by enhancing self-consciousness and a clearer sense of perspective.

7.3.3 Supporting professionals' reflection and ethical sensitivity

Having a structure for discussing value decisions like this enables a conversation to come together that also serves as a form of psychosocial support, which takes us to the third dimension of dialogue. Healthcare professionals dealing with difficult decisions and situations are at risk of being burdened by moral distress, a psychological concept that refers to the anger, frustration, guilt and powerlessness that professionals experience in situations in which they are unable to practice according to their ethical standards (see, for example, Kälvemark et al. 2004; Hamrick & Blackhall 2007; Sundin-Huard & Fahu 1999). Moral distress is widely researched in nursing science, and the results show that nurses are more impacted by moral distress than physicians (for example, Hamrick & Blackhall 2007), even though physicians also have been found to experience some forms of moral distress (for example, Forde & Aasland 2008).

Sharing thoughts about value decisions and other moral dimensions of healthcare potentially creates not only a forum for intellectual debate but also a space for compassion. Moral distress adds to the emotional burden of physicians' and nurses' work, such as dealing with patients' and their families' expressions of fear, anger and grief. This predisposes the providers to an emotional labor that consists of both being a target of other's negative emotions and of having to regulate their own emotional responses (Grandey et al. 2012). Psychological common wisdom holds that it is better to talk about things and share experiences and feelings with other people than to suppress them or deal with them alone. Moral dialogue may not be the primary form of support; nevertheless, it can offer one component to the wider constellation that helps healthcare professionals find psychological balance in their demanding work. This is important not only to support the professionals but also to guarantee the quality of patient care, because healthcare professionals' decreased job performance, including absenteeism and turnover, harms both patients and healthcare organizations (Grandey et al. 2012; LeBlanc et al. 2007).

Safeguarding healthcare professionals' wellbeing with psychosocial support structures may also be a way to decrease professionals' level of cynicism, meaning a decline in empathy and emotional neutralization that are especially identified as occurring in medical practice (for example, Peng, Clarkin & Doja 2018). Cynicism in medical practice has been linked to conflicts between the formal and hidden curricula in medical school. Tensions arise when trainees enter the clinical work environment and discover that the values of patient-centered care are challenged by the time-pressured, arduous realities of practicing medicine (Ibid.). Lack of empathy and “freezing” oneself emotionally are reasons for concern, because one might speculate that those may influence whether someone can treat other people—patients and coworkers—as moral equals (term borrowed from Bærøe & Norheim 2011). Providing structures that encourage moral dialogue may be one way to strengthen professionals’ ability to confront their work with ethical sensitivity. This is not only because dialogue widens horizons and opens new interpretative frames; it also allows the professional herself to be encountered as a full person with feelings and moral considerations.

7.3.4 Consolidating professional knowledge for the patient’s benefit

The fourth dimension considers dialogue as a forum for interprofessionality. I briefly discussed this theme and its definitions at the beginning of the thesis regarding the differences between multiprofessionality and interprofessionality. Roughly defined, multiprofessionalism means different professionals working side by side; interdisciplinarity means them working together with a shared intention that embraces the meeting of different professional epistemologies through dialogue. Thus, unlike multiprofessionalism, interprofessionalism does not mean the coexistence of different professionals following orders and fulfilling roles; like interdisciplinarity, it exists “in the will to create bridges between various possible explanations that emerge through the categorization of objects” (Couturier et al. 2008, 347). Interprofessionality, thus, consists of a “transformation of disciplines that are not only co-present but also co-active” (ibid., 342).

A practical example is when **interprofessional** teams’ patient treatment plans are developed together and each team member is aware of the other professionals’ competencies and professional training (Steffen, Zeiss & Karel 2014, 735–736). Interprofessional team members who are working in this way treat each other as colleagues who bring a range of both unique and overlapping skills to patient care (Zeiss and Steffen 1998). In contrast, **multiprofessional** teamwork occurs when the professionals develop their own individual assessment and treatment plan for the patient and share their treatment plan with the rest of the team only after doing this, simply to keep others informed. Multiprofessional teams are typically hierarchically organized with the highest status discipline in charge, whereas interprofessional teams adopt a more flexible approach toward discipline-specific roles. This naturally reflects a very different kind of attitude and demands different knowledge and skills from the collaborating professionals than does multiprofessionalism. (Steffen, Zeiss & Karel 2014, 735–737.)

Studies of the impacts of interprofessionalism versus multiprofessionalism as ways to organize healthcare teams indicate that the inadequate ability of healthcare professionals to work together implicates "a range of adverse outcomes, including lower provider and patient satisfaction, greater numbers of medical errors and other patient safety issues, low workforce retention, system inefficiencies resulting in higher costs, and suboptimal community engagement" (Institute of Medicine Committee 2015, 12). Neither medical outcomes nor patient satisfaction are topics for this thesis, but these findings raise questions about whether being able to confront ethical quandaries and moral considerations together (rather than separately) also count. Having a forum for interprofessional moral dialogue may expand horizons in enlightening ways, increase mutual understanding, build a sense of shared responsibility in the team and help support other forms of interprofessionalism in daily teamwork.

However, I realize this might be a long shot. I recently talked with Finnish nurses, curious about their views on whether interprofessionalism like this was a real goal in the cancer unit of a university hospital where they worked. They laughed and informed me that they only meet with physicians on a monthly basis. More shockingly, I learned that the nurses and physicians have their own profession-bound coffee rooms. Perhaps this is an uninformed outsider's perspective, but it seems hard to see all professionals working efficiently to cure cancer if they cannot even have coffee together. Even though anecdotal evidence like this does not count as appropriate data, it seems presumable that there is room for improvement in the interprofessional practices of Finnish healthcare. Perhaps ethics can be a good place to start the improvements, because ethical practices are an interest naturally shared by all professional groups in the healthcare nexus.

7.3.5 Bridging practical and theoretical wisdom

The fifth dialogue dimension considers the interlinking of ethical practice and ethical theory. As a social scientist, I have been on a mission throughout this thesis to both understand the ethical landscapes of practicing clinical professionals and to roam in university seminars discussing ethics with philosophers and other academics. Both worlds are fascinating, but my experience of having been in both spaces is like being cut in half: simply, it seems that there is no common space between the two; rather, one must choose to be in one or the other.

I have personally made the choice to try to understand a little bit of both worlds, and while this has come with the price that my knowledge is shallow in both arenas, I see a certain value of being in between. I have been in rooms making my (apparently unconvincing) contribution to the trolley problem with academics; I have also heard clinicians sharing heartbreaking and anxiety-arousing stories about babies who just did not have a chance for life. What I have learned from both worlds is that both are filled with incredible wisdom, perspectives and stories, yet it seems that a bridge in between them—the social glue that could interlink them—is lacking. This may mean, in practice, that nurses may not even be able to identify that the anxiety they are experiencing stems from a moral dilemma. Philosophers, however, may never encounter the kind of soul-gripping situation of the risk of halting their heart for a second—that physical and emotional moral experience that ICU nurses have come to know so closely. It is a shame that these people may never meet and teach each other what they know, because it seems as if they have much to offer to each other and could help each other understand the questions they are dealing with in more depth.

I make the point with these ideas that moral dialogue, again, offers a space for the different perspectives and knowledge to be shared, forming a forum for people to learn from each other. It allows a channel for exchanging ideas and explanations. Dialogue is more than the sum of its parts, but the parts—the knowledge and perspectives that people bring to the table—make all the difference. Nevertheless, it is important to notice that dialogue is more than argumentation or an act of looking for a compromise. According to William Isaacs (2008), dialogue is “a conversation with a center, not sides.” Isaacs defines this interaction as an action of not only solving but **dissolving** problems through the act of thinking together rather than separately. This sentiment refers to dialogue being more than just trying to reach agreements—rather, dialogue creates a fertile context from which new agreements, new framings of the problems and their potential solutions, may arise. (Ibid., 19.)

The idea of dialogue as a form of thinking together draws us back to social constructionism, the theory shaping the very starting point for my inquiries. I studied the social construction of ethics in healthcare professions and found great differences in worldviews and ways of knowing about ethics. I ended up by highlighting the value and possibilities that open-ended and diverse ethical dialogue may have to offer. The reason for ending up with the idea of dialogue is understanding that we actively **construct** the world we live in. We need practices to shape and support the meeting of different professional epistemologies if we want to construct efficient teamwork. My work has been qualitative by nature and thereby lacks statistical generalizability, yet a pressing need to further advance ethical dialogue is reflected in the way the healthcare professions in Finland have constructed islands of professional isolation and insularism that appear to exclude other professions' perspectives. We must act to construct narratives that bring together rather than separate professionals if we are to take interprofessionality, teamwork and, frankly, even healthcare ethics seriously. The social construction of shared responsibility needs a space to exist, and that space is dialogue.

7.3.6 Imagination expands opportunities

> "[O]ur moral imagination depends in large measure on various structures of imagination, such as images, image schemas, metaphors, narratives and so forth. Moral reasoning is thus basically an imaginative activity, because it uses imaginatively structures concepts and requires imagination to discern what is morally relevant in situations, to understand empathetically how others experience things, and to envision the full range of possibilities open to us in a particular case." (Johnson 1993, ix–x.)

I have deliberately left the point about moral imagination to the end, not only because it perhaps appears as the most ambiguous and pollyannaish of all my justifications for dialogue but also because it is probably the most important one of all. This is because imagination emphasizes open-mindedness and open-endedness in all human inquiries as its virtue. It takes us from the domain of strict analytical thinking to a different territory, into a childlike, liberated, creative inquiry.

Philosopher Mark Johnson (1993) claimed that moral action and decision making build on people's ability to **imagine** possible outcomes and empathize with the people involved in the situation. This view of morality as an act of imagination differs radically from the more traditional idea that living morally is a matter of finding the appropriate principles, followed by living up to those principles with the help of willpower and strength of character. Moral action is, thus, constructed as rule following within this framework, yet one does not have to look very far to see that rules easily come into tension. A classic and ever-repeating dilemma is the case in which a healthcare professional feels that responding to the patient's wishes does more harm than good—here, the principles of respecting the patient's autonomy and beneficence come into conflict. Taking the basis of understanding ethics as rule following can create a deep tension for the professional, and this tension cannot be overcome by appealing to the principles that create the tension.

Moral imagination is looking beyond the principles to find solutions. It is the act of connecting oneself to the situation, experiencing empathy and looking for alternatives with an open mind. Nevertheless, moral imagination can be easily discarded by saying it is simply subjective without any shared common moral ground—even an "anything goes" approach. And yet, by looking at the human experience and cognition from the viewpoint of social constructionism, it seems obvious that moral considerations are fundamentally shared—otherwise they would not exist. Moral imagination is simply letting the play of shared ideas and worldviews to happen through dialogue. The assumption here is that a solution comes into view through imaginative moral dialogue. It takes courage and an open mind, though, to put oneself in such an open-ended process.

Imagination is also the root of empathy. It is only through imagination that I could choose to put myself in your shoes and to envision what it would feel like to view the situation from that perspective. Without such imagination, I can only either see my own view or refer to cold rationalizations of the situation. It is hard to imagine ethical professionalism without empathy, at least in the healthcare setting.

Uncertainty cannot be handled by referring to principles that create tensions in themselves. We need flexible structures that acknowledge moral thinking as a social, emotional, situational and imaginative process, a process that does not hide behind principles or written word, does not deny the realities of the situation, but faces them head on.

We are facing the situation in Finland that the process is lacking, and we are losing opportunities to learn from each other because of it.

7.4 Limitations and suggestions for future research

There are many reasons why a reader may doubt the benefits of the kind of open-ended and pluralistic dialogue that I suggest as a potential way to approach moral uncertainty in the healthcare environment. One may not "believe" in such a method. In a way, all ways of looking at things come down to what we believe. If one "believes" in social construction, constructions appear. It is hard to know where believing ends and knowing starts, or vice versa. We are ultimately limited by our own worldviews and the boundaries of our imagination. This natural limitation also concerns the findings and conclusions of this thesis. I consider some of the limitations of this thesis in this chapter.

One obvious limitation concerns the pragmatic dimension of the kind of moral dialogue for which I advocate. I have not taken any view about how this dialogue should be organized; that is, should it entail a specific method or a certain procedure? I have deliberately narrowed my conclusion down to the argument for **why** moral dialogue is valuable for (Finnish) healthcare because taking up more than this would be a massive amount of work that would eventually go beyond the practical limits of one thesis. However, further testing some of the existing conversation methods developed by others (for example, Dubler & Liebman 2011; Fiester 2015; Metselaar, Molewijk &

Widdershoven 2015) would be a natural focus for future research efforts in Finnish healthcare.

Another limitation concerns the fact that I have not focused on any specific ethical dimension or question in this thesis; rather, I have examined the studied professionals' understandings of ethics as a wider theme. This results in this thesis being more like a **general** view over healthcare ethics rather than an in-depth, detailed study of a certain topic area or profession. I chose this general perspective because I wanted to bring the larger-scale cultural differences between the professions into light. However, it is natural that this kind of approach will carry a certain ambiguity, a roughness, that explores perhaps some parts of the forest but not the trees, so to speak. Understanding a social phenomenon in depth requires that we understand both the details and the whole. It would, thus, be beneficial to study further how the studied professions approach certain ethical themes—such as end-of-life care or organ donation, for example—from their own viewpoints. It would also be interesting to delve more closely into one profession alone, focusing both on everyday ethics in action and on general professional discourse.

One limitation to note is that the case I build in this thesis, advocating for an approach of interprofessional ethical dialogue, no doubt overlooks some crucial social realities, such as tensions between different professional roles, hierarchies and other potential points of collision that can, in practice, be barriers to organizing interprofessional collaboration. This may reflect the fact that looking at a social reality from an academic position (and not as an actual participator) has the potential to generate an overtly idealistic conception of reality, a detached "view from nowhere" (quoting Nagel 1986) that does not fully connect with everyday reality. I acknowledge this detachment to be, in some part, a function of this thesis as well. However, I hope that the empirical qualities of the thesis can nevertheless open some viewpoints that are rooted in the practical world and, thus, hopefully resonate with practicing healthcare professionals.

No doubt my work would have also benefitted from deeper academic rigor on the concepts of **profession** and **professionalism**, connecting more closely to the academic tradition of the sociology of the professions. After all, these concepts have only been defined loosely in this thesis. However, my focus has been on understanding the discourses of ethics in different healthcare professions, and because of this, I have not studied the construction of the professions or their professional claimsmaking in itself, but rather, the perspectives the studied professions take to the topic of healthcare ethics. Focusing on ethics in this way rather than the construction of professionalism has deepened my focus on the research questions. A fruitful idea for future research, however, would be to connect this work to the construction of professions and professionalism in the healthcare environment.

Finally, it should be noted that I have taken a strong view on healthcare ethics in this thesis. I acknowledge that such great claims carry a much larger burden of evidence than could possibly be met in these humble pages. I understand that making a strong argument has the potential to be overly simplistic and to render the nuances and complexities of the reality invisible. Thus, it is important to note that the claims I make should be seen as a **perspective** that seeks to prompt further debate by others as well, staying open to criticism and differences in opinion. Niels Bohr, quoted in the publication of the substudy on moral expertise, has stated that the opposite of a correct statement is a false statement, but the opposite of a profound truth may be another profound truth. I have been in service of the truth that there is value in interprofessional ethical dialogue. However, it is also possible that this truth eclipses another truth that could, on the contrary, bring attention to the value of intraprofessional ethics. And in the end, a lot of space likely exists in between the two that I have not paid attention to.

7.5 In the end

Having started the research with positive curiosity toward bioethics and the questions that bioethics has raised about professional ethics and clinical practices, I conclude with the same fondness toward bioethics. My understanding is that clinical bioethics practices can serve as a bridge to confront ethical questions in a way that opens space for a diversity of voices. This does not necessarily provide answers but rather methods and an attitude of inclusivity and open-endedness as the building blocks of ethical deliberation (see also Saxén 2017).

Bioethics as a discipline and paradigm for healthcare ethics makes room for spaces in which ethical quandaries can take shape and be negotiated, but bioethicists do not own the questions nor the spaces. Bioethicists are more like creators than owners of moral space: They have an agency of opening, not controlling, conversations. Nevertheless, adopting this kind of attitude of open-endedness in healthcare ethics means stepping out of the traditional, more profession-based ethos and making space for an interdisciplinary and pluralistic way of dealing with healthcare ethics.

The term for doctoral dissertation in Finnish is “väitöskirja,” combining the word “väitös” originating from the verb “väittää”—to allege, claim, or argue—with the word “kirja,” meaning a book. A literal translation is, thus, “a book of argumentation.” My argument is simple. **Finnish healthcare needs bioethics—but not simply because of bioethics itself but because of dialogue that fosters an attitude of the permanence of uncertainty in healthcare.** The main justification for this view is the realization that the existence of uncertainty in healthcare is a given fact, not a consequence of unfortunate circumstances or colliding principles, and that dialogue is a powerful mechanism for meeting uncertainty in a pluralistic and open-ended manner. Trying to deny or escape this inevitability of uncertainty would mean establishing a system in which professional control overpowers human vulnerability and autonomy. We would be taking the “care” out of healthcare in such a system: Perhaps we would indeed be healthy but not cared for.

Recognizing uncertainty, thus, as a permanent condition opens space for a discourse of healthcare ethics that emphasizes that professionals should continue to stay humble in the face of health and illness, vulnerability and the limits of technical knowledge and expertise. This is the very antithesis of technocracy. It demands professionals to share an open-ended storyline, to understand both their own and their patients’ worldviews, and to respect the differences between moralities. Recognizing uncertainty in this way is not, however, an easy path to walk. Healthcare professionals admitting to the limits of their knowledge and skill requires a great deal of courage. “Courage is the first of human qualities because it is the quality which guarantees the others," Aristotle stated. Perhaps one could also say that uncertainty is the first insight of healthcare ethics because it guarantees all the others.

For a country like Finland, however, adopting clinical bioethics practices would mean a leap of faith that comes with everything new. It takes courage for a healthcare professional to admit being confused and not knowing the answers. On a wider cultural and institutional level, it takes courage to say that perhaps the way to deal with ethics intraprofessionally sets standards for professional conduct, but in the big picture, profession-based ethics is not a tool sharp enough to meet all the everyday needs connected to clinical-ethical uncertainty. This is because uncertainty abides no matter how tight we make the rules and laws we constitute. It is important, then, to remember that in ethics, not knowing all the answers is a strength, not a weakness. This opens space for different ideas and perspectives—a whole world that one may not know otherwise.

Living with uncertainty is not a new idea. Healthcare ethics has always dealt with the complexity of moral life. My suggestion is only to take better care of making visible the understanding—the discourse—that recognizes the fact that uncertainty will never cease. It is the very basis of the kind of moral life that takes the fragility of the human condition and the social division of values seriously. Healthcare professionals and bioethicists alike are in crucial roles for keeping the kind of moral space open that recognizes this uncertainty as its very foundation.

That is because, in the end, should we lose this ingrained sense of uncertainty, we would lose the very wisdom of humanity in healthcare.

Data sources

Lääkäriliitto (2014) Eettiset ohjeet. [Ethical guidelines.] Updated version. Helsinki: The Finnish Medical Association. Read and saved from online source on December 30, 2016. See Appendix 1.

Ranta, I. (Ed.) (2012). Sairaanhoitajan eettiset pelisäännöt. Helsinki: Sairaanhoitajaliitto Fioca. [Ethical guidelines for nurses. Helsinki: The Finnish Nurses Association Fioca.]

Saarni, S., Kattelus, M., & Nummi, V. (Eds.) (2013). Lääkärin etiikka. Helsinki: Lääkäriliitto and Suomen Hammaslääkäriliitto. [Physician's ethics. Helsinki: The Finnish Medical Association and the Finnish Dental Association.]

Sairaanhoitajaliitto (1996) Sairaanhoitajien eettiset ohjeet. [Ethical guidelines for nurses.] Helsinki: Sairaanhoitajat. Read and saved from online source on December 30, 2016. See Appendix 2.

References

Abbott, Andrew (1983) Professional Ethics. American Journal of Sociology, 88(5): 855–885.

Abma, Tineke A. (2019) Dialogue and deliberation: New approaches to including patients in setting health and healthcare research agendas. Action Research 17(4): 429–450

Ahmed, Sara (2006) Queer phenomenology: orientations, objects, others. Durham: Duke University Press.

Allan, Kenneth (2007) The Social Lens. An invitation to social and sociological theory. Thousand Oaks, CA: Sage.

Andrade, Gabriel (2019) Medical Ethics and the Trolley Problem. Journal of Medical Ethics and History of Medicine, 12(3).

Archard, David (2011) Why Moral Philosophers Are Not And Should Not Be Moral Experts. Bioethics 25(3): 119–127.

Aristotle (2020) The Nichomachean Ethics. Oxford's Scholarly Editions Online. Oxford's World Classics, Revised Edition. Oxford and New York: Oxford University Press.

Bærøe, Kristine & Norheim, Ole Frithjof (2011) Mapping out structural features in clinical care calling for ethical sensitivity: A theoretical approach to promote ethical competence in healthcare personnel and clinical ethics support services (CESS). Bioethics 25(7): 394–402.

Beauchamp, Tom L. & Childress, James F. (2012) The Principles of Biomedical Ethics. Fifth Edition. Oxford and New York: Oxford University Press.

Berger, Peter L. & Luckmann, Thomas (1966) The Social Construction of Reality: A treatise in the sociology of knowledge. New York: Penguin Books.

Bergman-Pyykkönen, Marina (2017) Towards interprofessionalism in developing family mediation in Finland. Social Work Education 36(5): 575–590.

Berlinger, Nancy, Jennings, Bruce & Wolf, Susan M. (2013) The Hastings Center Guidelines for Decisions on Life-Sustaining Treatment and Care Near the End of Life. 2nd Edition. Oxford and New York: Oxford University Press.

Blommaert, Jan & Bulcaen, Chris (2000) Critical Discourse Analysis. Annual Review of Anthropology 29(1): 447–66.

Brock, Dan (2007) Health Care Resource Prioritization and Rationing: Why is it so difficult? Social Research 74(1): 125–148.

Brugére, Fabienne (2017) Care Ethics: The introduction of care as a political category. Leuven: Peeters.

Bruun, H., Lystbaek, S.G., Stenager, E., Huniche, L. Pedersen, R. (2018) Ethical challenges assessed in the clinical ethics Committee of Psychiatry in the region of Southern Denmark in 2010–2015: A qualitative content analysis. BMC Medical Ethics 19: 62, https://doi.org/10.1186/s12910-018-0308-z.

Bruun, Henriette, Pedersen, Reidar, Stenager, Elsebeth, Backer Mogensen Christian & Huniche, Lotte (2019) Implementing Ethics Reflection Groups in Hospitals: An action research study evaluating barriers and promotors. BMC Medical Ethics 20: 49, https://doi.org/10.1186/s12910-019-0387-5.

Bulger, Jeffrey W. (2007) Principlism. Teaching Ethics 8(1): 81–100.

Burr, Viv (2015) Social Constructionism. In Wright, James D. (Ed.): International Encyclopedia of Social and Behavioral Sciences. 2nd Edition. Amsterdam: Elsevier.

Burr, Vivien (1995) Social Constructionism. Routledge: Abingdon-on-Thames, U.K.

Bykvist, Krister (2017) Moral uncertainty. Philosophy Compass 12(3).

Callahan, Daniel (1973) Bioethics as a Discipline. The Hastings Center Studies, 1 (1): 66–73.

Callahan, Daniel (2005) Bioethics and Culture Wars. Cambridge Quarterly of Healthcare Ethics 14: 424–431.

Callahan, Daniel (2012) In Search of the Good: A life in bioethics. Cambridge, MA and London, UK: The MIT Press.

Churchill, Larry R. (1999) Are We Professionals? A critical look at the social role of bioethicists. Daedalus 128(4): 253–274.

Coughlin, Michael D. & Watts, John (1993) A Descriptive Study of Healthcare Ethics Consultants in Canada: Results of a national survey. HEC Forum 5(3): 144–164.

Couturier Yves, Gagnon, Dominique, Carrier, Sébastien & Etheridge, Francis (2008) The interdisciplinary condition of work in relational professions of the health and social care field: A theoretical standpoint. Journal of Interprofessional Care 22(4), 341–351.

Cribb, Alan & Gewirtz, Sharon (2015) Professionalism. Cambridge, UK: Polity Press.

Cross, Ben (2015) Moral Philosophy, Moral Expertise, and the Argument from Disagreement. Bioethics 30(3): 188–194.

Crosthwaite, Jan (1995) Moral Expertise: A Problem in the Professional Ethics of Professional Ethicists. Bioethics 9(4):362–379

Daniels, Norman & Sabin, Jim (2008) Setting Limits Fairly: Learning to share resources for health. Oxford and New York: Oxford University Press.

Danziger, Kurt (1997) The varieties of social construction. Theory and Psychology 7(3): 399–416.

Darwall, Stephen (Ed.) (2003) Deontology. Malden, MA: Blackwell Pub.

Devettere, Raymond J. (2002) Introduction to Virtue Ethics: Insights of the Ancient Greeks. Washington, D.C.: Georgetown University Press.

Dicicco-Bloom, Barbara & Crabtree, Benjamin F. (2006) The Qualitative Research Interview. Medical Education 40(4): 314–321.

Dickenson, Donna (2012) Bioethics. London: Hodder Education. Drane, James F. (1994) Clinical Bioethics: Theory and practice in medical-ethical decision-making. Kansas City: Sheed & Ward.

Dubler, Nancy N. & Liebman, Carol B. (2011) Bioethics Mediation: A guide to shaping shared solutions. Revised and Expanded Edition. Nashville, TN: Vanderbilt University Press.

van Dyjk, Teun A. (1985) Introduction: The role of discourse analysis in society. In van Dyjk, T. A. (Ed.): Handbook of Discourse Analysis. Vol. 4. London: Academic Press, 1–8.

Dzur, Albert W. (2008) Democratic Professionalism: Citizen participation and the reconstruction of professional ethics, identity, and practice. University Park: Penn State University Press.

Dzur, Albert (2018) Rebuilding Public Institutions Together: Professionals and citizens in participatory democracy. Ithaca and London: Cornell University Press.

Edwards, Derek & Potter, Jonathan (1992) Discursive psychology. London, Thousand Oaks and New Delhi: Sage.

ETENE. The National Advisory Board on Social Welfare and Health Care Ethics. Online resource. https://etene.fi/en/frontpage. Read August 27, 2019.

Fairclough, Norman (1992) Discourse and Social Change. Cambridge, UK: Polity Press.

Fairclough, Norman (2010). Critical Discourse Analysis (2nd ed.). London: Routledge.

Fairclough, Norman (2001) Language and Power (2nd ed.). Harlow, UK: Longman.

Fiester, Autumn (2015) Neglected Ethics: Clinical ethics consultation and the prospects for closure. The American Journal of Bioethics 15(1): 29–36.

Finlex 559/1994 (1994) Health Care Professionals Act. Issued in Naantali 28 June 1994. Helsinki: Ministry of Social Affairs and Health.

Foot, Philippa (1967) The Problem of Abortion and the Doctrine of the Double Effect. Republished in Foot, P. (2002): Virtues and Vices, and other essays in moral philosophy. Oxford and New York: Oxford University Press.

Førde, Reidun, Pedersen, Reidar & Akre, Victoria (2008) Clinicians' Evaluation of Clinical Ethics Consultations in Norway: A qualitative study. Medicine, Health Care and Philosophy 11(1): 17–25.

Forde, R. & Aasland, O. G. (2008) Moral Distress Among Norwegian Doctors. Journal of Medical Ethics 34(7): 521–525.

Foucault, Michel (1995) Discipline and Punish: The Birth of a Prison. London, UK: Penguin.

Foucault, Michel (1998) The Will to Knowledge: History of sexuality vol 1. London: Penguin.

Fournier, Veronique, Rari, Eirini, Førde, Reidun, Neitzke, Gerald, Renzo Pegoraro, Renzo & Newson, Ainsley J. (2009) Clinical ethics consultation in Europe: a comparative and ethical review of the role of patients. Clinical Ethics 4(3): 131–138.

Freidson, Eliot (1986) Professional Powers: A study of the institutionalization of formal knowledge. Chicago, IL: University of Chicago Press.

Freidson, Eliot (1988) The Profession of Medicine: A study of the sociology of applied knowledge. Chicago and London: University of Chicago Press.

Fox, Ellen, Berkowitz, Kenneth, Chanko, Barbara L. & Powell, Tia (2015) National Center for Ethics in Health Care, Ethics Consultation: Responding to Ethics Questions in Health Care. 2nd ed. Washington, D.C.: U.S. Department of Veterans Affairs. Online resource available at https://www.ethics.va.gov/docs/integratedethics/ec_primer_2nd_ed_080515.pdf. Read August 28, 2019.

Fox, Ellen, Myers, Sarah & Pearlman, Roberta (2007) Ethics Consultation in United States Hospitals: A national survey. American Journal of Bioethics 7(2): 13–25.

Galletta, Anne (2012) Mastering the semi-structured interview and beyond: From research design to analysis and publication. New York, NY: NYU Press.

Gilligan, Carol (1982) In a Different Voice: Psychological theory and women’s development. Cambridge, MA and London: Harvard University Press.

Goodwin, Charles (1994) Professional Vision. American Anthropologist 96(3): 606–633.

Gordon, John-Stewart (2014) Moral Philosophers Are Moral Experts! A Reply to David Archard. Bioethics 28(4): 203–206.

Grandey, Alicia, Foo, Su Chuen, Groth, Markus & Goodwin, Robyn E. (2012) Free To Be You and Me: A climate of authenticity alleviates burnout from emotional labor. Journal of Occupational Health Psychology 17(1): 1–14.

Greenberg, R. A., Anstey, K. W. & Macri, R. (2013) Bioethics Consultation Practices and Procedures: A Survey of a Large Canadian Community of Practice. HEC Forum 26: 135–146.

Habermas, Jürgen (1987a) Knowledge and Human Interests. Translated by Jeremy J. Shapiro. Original German text 1968. Cambridge, UK and Maiden, MA: Polity Press.

Habermas, Jürgen (1987b) The Theory of Communicative Action, Vol 2. Lifeworld and System: A Critique of Functionalist Reason. Boston, MA: Beacon Press.

Hamrick, Ann B. & Blackhall, Leslie J. (2007) Nurse-physician perspectives on the care of dying patients in intensive care units: Collaboration, moral distress, and ethical climate. Critical Care Medicine 25(2): 422–429.

Heitman, Elizabeth (1995) Institutional Ethics Committees: Local perspectives on ethical Issues in medicine. In Bulger, R.E., Meyer Bobby, E., Fineberg H.V. (Eds.): Society's Choices: Social and ethical decision-making in biomedicine. Washington, D.C.: The National Academies Press.

Husserl, Edmund (1970) The Crisis of European Sciences and Transcendental Phenomenology. Translated by David Carr. Evanston, IL: Northwestern University Press.

Hämäläinen, Nora (2016) Descriptive ethics: What does moral philosophy know about morality? London, UK: Palgrave Macmillan.

Häyry, Matti (2010) Rationality and the Genetic Challenge. Making people better? Cambridge, UK: Cambridge University Press.

Iltis, Ana S. & Rasmussen, Lisa M. (2016) The ”Ethics” Expertise in Clinical Ethics Consultation. The Journal of Medicine and Philosophy 41(4): 363–368.

Institute of Medicine Committee (2015) Measuring the Impact of Interprofessional Education on Collaborative Practice and Patient Outcomes. Washington, D.C.: National Academies Press.

Isaacs, William (2008) Dialogue and the art of thinking together. New York, NY: Currency.

In Denzin & Lincoln (Eds.) (1998) Strategies of Qualitative Inquiry. Thousand Oaks, CA: SAGE Publications.

Jennings, Bruce and Moreno, Jonathan D. (2011) Bioethics in the United States: Contested terrain for competing visions of American liberalism. In Myser, Catherine (Ed.) (2011) Bioethics around the Globe. Oxford, UK and New York, NY: Oxford University Press.

Johnson, Mark (1993) Moral Imagination: Implications of cognitive science for ethics. Chicago, IL and London, UK: The University of Chicago Press.

Joint Commission (1992) Accreditation Manual for Hospitals. Oak Park, IL: Joint Commission on Accreditation of Healthcare Organizations.

Jonsen, Albert (2000) A Short History of Medical Ethics. Oxford, UK and New York, NY: Oxford University Press.

Jonsen, Albert R. (1998) The Birth of Bioethics. New York, NY and Oxford, UK: Oxford University Press.

Jonsen, Albert R., Siegler, Mark & Winslade, William J. (2010) Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine. New York, NY: McGraw Hill Medical.

Jorgensen, Marianne and Phillips, Louise (2002) Discourse Analysis as Theory and Method. Thousand Oaks, CA: SAGE Publications.

Kessels, Jos (2001) Socrates Comes to Market. Reason in Practice 1(1): 49–70.

Kuipers, Joel C. (1989) “Medical Discourse” in Anthropological Context: Views of Language and Power. Medical Anthropology Quarterly 3(2): 99–123.

Kälvemark, Sofia, Höglund, Anna T., Hansson, Matts G., Westerholm, Peter & Arnetz, Bengt (2004) Living with conflicts-ethical dilemmas and moral distress in the health care system. Social Science and Medicine 58(6): 1075–1084.

Larrabee, Mary Jeanne (2016) An Ethic of Care: Feminist and Interdisciplinary Perspectives. Milton Park, Abingdon-on-Thames, UK: Taylor and Francis.

Laclau, Ernesto and Mouffe, Chantal (1985) Hegemony and the Socialist Strategy. London, UK: Verso.

de Lazari-Radek, Katarzyna & Singer, Peter (2017) Utilitarianism: A Very Short Introduction. Oxford, UK and New York, NY: Oxford University Press.

Lagerspetz, Eerik (2008) Ethical Expertise in Democratic Societies. In Launis, Veikko & Räikkä, Juha (Eds.): Genetic Democracy: Philosophical perspectives. New York: Springer.

Larson, Magali Sarfatti (1977) The Rise of Professionalism: A Sociological Analysis. Berkeley: University of California Press.

Launis, Veikko & Räikkä, Juha (Eds.) (2008) Genetic Democracy: Philosophical perspectives. New York, NY: Springer.

LeBlanc, Pascale M., Hox, Joop J., Schaufeli, Wilmar B., Taris, Toon W. & Peeters, Maria C. W. (2007) Take Care! The Evaluation of a Team-Based Burnout Intervention Program for Oncology Care Providers. Journal of Applied Psychology 92(1): 213–227.

Lock, Andrew & Strong, Thomas (2010) Social Constructionism: Sources and stirrings in theory and practice. Cambridge, UK: Cambridge University Press.

Louhiala, Pekka, Saarni, Samuli, Hietala, Katri & Pasternack, Amos (2012) Physicians’ Ethics Forum: a web-based ethics consultation service. Journal of Medical Ethics 38(2): 83–86.

MacIntyre, Alasdair (1981) After Virtue: A study in moral theory. Notre Dame, IN: University of Notre Dame Press.

MacIntyre, Alasdair (1988) Whose Justice? Which Rationality? Notre Dame, IN: University of Notre Dame Press.

McCracken, Grant (1988) The Long Interview. London: Sage.

Melrose, Sherri (2010) Naturalistic Generalization. In: Mills, Albert J., Eurepos, Gabrielle & Wiebe, Elden (Eds.): Encyclopedia of Case Study Research. Volume 1. Los Angeles, CA and London, UK and New Delhi, Singapore and Washington D.C.: A SAGE Reference Publication.

Metselaar, Suzanne, Molewijk, Bert & Widdershoven, Guy (2015) Beyond Recommendation and Mediation: Moral Case Deliberation as Moral Learning in Dialogue. The American Journal of Bioethics 15(1): 50–51.

Miller, Franklin G. & Truog, Robert D. (2012) Death, Dying and Organ Transplantation: Reconstructing medical ethics at the end of life. Oxford, UK and New York, NY: Oxford University Press.

Miller, Frankling G. & Truog, Robert D. (2008) Rethinking the ethics of vital organ donations. Hastings Center Report 38(6): 38–46.

Molewijk, B., Abma, T., Stolper, M. & Widdershoven, G. (2008) Teaching ethics in the clinic: The theory and practice of moral case deliberation. Journal of Medical Ethics 34: 120–124.

Mouffe, Chantal (2005) The Democratic Paradox. London, UK: Verso.

Mouffe, Chantal (2013) Agonistics: Thinking the World Politically. London, UK: Verso.

Myser, Catherine (Ed.) (2011) Bioethics around the Globe. Oxford, UK and New York, NY: Oxford University Press.

Nagel, Thomas (1986) The View from Nowhere. Oxford, UK and New York, NY: Oxford University Press.

Nikunen, Outi (2018) Eettisen keskustelun koulutus terveydenhuollon henkilöstön eettisen osaamisen tukena: Kyselytutkimus osallistujille. [Ethics discussion education for supporting the ethical competence of health care professionals: A survey for the participants.] Master's Thesis. Kuopio and Joensuu: University of Eastern Finland.

Noble, Cheryl, Singer, Peter, Avorn, Jerry, Wikler, Daniel, Beauchamp, Tom (1982) Ethics and Experts. The Hastings Center Report 12 (3): 7–15.

Pedersen, Reidar, Akre, Victoria & Førde, Reidun (2009) Barriers and Challenges in Clinical Ethics Consultations: The experiences of nine clinical ethics committees. Bioethics 23(8): 460–469.

Peltoniemi, Outi, Olsen, Päivi, Juusola, Kristian & Lehtinen, Satu (2018) Kliinisen etiikan työryhmä tukena vaikeissa päätöksissä. [Clinical ethics workgroup as a support for difficult decision-making.] Lääkärilehti 73(9): 586–587.

Peng, Jenny, Clarkin, Chantalle & Doja, Asif (2018) Uncovering cynicism in medical training: a qualitative analysis of medical online discussion forums. BMJ Open, doi:10.1136/bmjopen-2018-022883.

Phillips, N., & Hardy, C. (2002). Discourse analysis: Investigating processes of social construction. Thousand Oaks, CA: Sage.

Poikkeus, Tarja (2019) Support for nurses' ethical competence: Organization and individual support by nurse leaders. Doctoral dissertation. Turku: University of Turku.

Poikkeus, Tarja, Numminen, Olivia, Suhonen, Riitta & Leino-Kilpi, Helena (2013) A Mixed-Method Systematic Review: Support for ethical competence of nurses. Journal of Advanced Nursing 70(2): 256-271.

Potter, Jonathan (2008) Naturalistic Data. In Given, Lisa M. (Ed.): The SAGE Encyclopedia of Qualitative Research Methods. Online edition.

Potter, Jonathan (1996) Representing Reality: Discourse, rhetoric and social construction. Thousand Oaks, CA: SAGE.

Rabinow, Paul (Ed.) (1984) The Foucault Reader: An Introduction to Foucault’s Thought. London, UK: Penguin.

Rasoal, Dara, Kihlgren, Annica, James, Inger & Svantesson, Mia (2016) What healthcare teams find ethically difficult. Nursing Ethics 23(8): 825–837.

Rosenberg, Charles E. (1999) Meanings, Policies, and Medicine: On the Bioethical Enterprise and History. Daedalus 128(4): 27–46.

Rothman, David J. (1991) Strangers at the Bedside: A history of how law and bioethics transformed medical decision-making. New Brunswick, NJ and London, UK: AldineTransaction.

Saumure, Kristie & Given, Lisa M. (2008) Data Saturation. Online Edition. In: Given, L. M. (Ed): The Sage Encyclopedia of Qualitative Research Methods. Thousand Oaks, CA: Sage.

Saxén, Heikki (2017) A Cultural Giant. An interpretation of bioethics in light of its intellectual and cultural history. Tampere: University of Tampere.

Shalit, Ruth (1997) When We Were Philosopher Kings: The rise of the medical ethicist. New Republic, April 28, 24–28.

Sher, Stephen & Kozlowska, Kasia (2018) Rethinking Healthcare Ethics. London, UK: Palgrave Pivot.

Silén, Marit, Ramklint, Mia, Hansson, Mats G. & Haglund, Kristina (2016) Ethics Rounds: An appreciated forum of ethics support. Nursing Ethics 23(2): 203–213.

Steffen, Ann M., Zeiss, Antonette M. & Karel, Michele J. (2014) Interprofessional geriatric healthcare: Competencies and resources for teamwork. In Pachana, N. & Laidlaw, K. (Eds.): Oxford Handbook of Clinical Geropsychology: International Perspectives. Oxford, UK and New York, NY: Oxford University Press, 733–752.

Sundin-Huard, Deborah & Fahy, Kathleen (1999) Moral distress, advocacy, and burnout: Theorizing the relationships. International Journal of Nursing Practice 5(1):8–13.

TENK (2019) The ethical principles of research with human participants and ethical review in the human sciences in Finland. Helsinki: Finnish National Board on Research Integrity TENK.

TENK (2012) Responsible conduct of research and procedures for handling allegations of misconduct in Finland. Helsinki: Finnish Advisory Board on Research Integrity TENK.

Tinker, C. and Armstrong, N. (2008) From the Outside Looking In: How an awareness of difference can benefit the qualitative research process. Qualitative Report 13(1): 53–60.

Truog, Robert (2007) Brain death: Too flawed to endure, too ingrained to abandon. Journal of Law, Medicine and Ethics 35(2): 273–281.

Veatch, Robert M. (2005) Disrupted Dialogue. Medical ethics and the collapse of physician-humanist communication (1770–1980). Oxford, UK: Oxford University Press.

Walker, Margaret Urban (1993) Keeping Moral Space Open: New images of ethics consulting. The Hastings Center Report 23(2): 33–40.

Widdershoven, Guy & Molewijk, Bert (2010) Philosophical Foundations on Clinical Ethics: A Hermeneutic Perspective. In Shildmann, J., Gordon, J. & Volmann, J. (Eds.): Clinical Ethics Consultation. Theories and Methods, Implementation, Evaluation. Farnham, UK: Ashgate, 37–51.

Yoder, Scot D. (1998) The Nature of Ethical Expertise. The Hastings Center Report 28 (6):11–19.

Zeiss, Antonette M. and Steffen, Ann M. (1998) Interdisciplinary Health Care Teams in Geriatrics: An International Model. In A. S. Bellack and M. Hersen (Eds.): Comprehensive Clinical Psychology 7: Clinical Geropsychology. Oxford, UK: Pergamon Press, 551–570.

Appendices

APPENDIX 1. Physicians’ Code of Ethics

Text as saved December 30, 2016. Translation by Salla Saxén, followed by the original text in Finnish.[13]

The physician’s task is responsible and demanding. In order for the physician to manage this duty, in addition to elaborate knowledge she must have a will to obey the ethical obligations that have abided in the profession for centuries. She achieves trust in her work based on her knowledge, professional skill, and personality. In accordance with these principles, the commission of the Finnish Physicians Union have 12.12.2014 accepted the following directions to be followed in the practice of the profession:

I

The obligation of the physician is to uphold and advance health, prevent and treat the illness of her patients and to alleviate their sufferings. In all her practice the physician must respect humanity and life.

A physician must never take part in torture, the enforcement of capital punishment, or other inhumane practice or the preparations of such practice.

II

With her behaviour and practice, the physician must uphold the respect and trust assigned to the profession and which is required by the duty.

III

The physician must treat her patients equally with justice and free of discrimination.

---

[13] Note that the Finnish language does not differentiate between genders in the third person pronoun. For consistence and clarity, I have used only the feminine form in the translation.

IV
The physician must respect the patient’s right to autonomy and support her participating in the decision-making of her own care. As much as possible, the actualization of autonomy must also be supported in the conditions in which the physician must act in spite of the patient’s will.

V
The physician must uphold and increase her knowledge and skillset. She must use and recommend only the kind of examinations and treatments that have been proved to be influential and appropriate based on medical knowledge and experience.

VI
The physician must advance the scientific research of her field. In medical research, the physician must adhere to the principle of informed consent and the other requisites in the Declaration of Helsinki.

VII
The physician must obey the confidentiality obligation and advance the confidentiality of medical reports.

VIII
The physician must treat the patient according to her need of help and compose her compensation on completed work only. The physician must not pursue unjustified material benefits.

IX
Giving testimonies and making statements, the physician acts as an impartial expert accepted by society. The statements must be based on medical evaluation that yields objective observations, and the critical examination of the background of the case.

X

In public performances, the physician must abide by careful considerations and avoid putting unnecessary emphasis on herself and present the patient in a respectful manner. The physician must base her statements on medical knowledge and experience.

XI

In her own behavior and action, the physician must foster and advance collegiality for the patient's benefit and to uphold a dignified spirit and good comradeship.

XII

In her work, the physician must act in an active manner to fulfil these duties and principles.

Original version:

Lääkärin tehtävä on vastuullinen ja vaativa. Tästä tehtävästä suoriutuakseen hänellä on oltava perusteellisten tietojen ohella halu noudattaa lääkärin jo vuosituhantisia eettisiä velvoitteita. Hän saavuttaa toiminnassaan luottamuksen tietojensa, ammattitaitonsa ja persoonansa perusteella. Näiden periaatteiden mukaisesti Suomen Lääkäriliiton valtuuskunta on 12.12.2014 hyväksynyt lääkäreiden noudatettaviksi ammattia harjoittaessaan seuraavat ohjeet:

I

Lääkärin velvollisuutena on ylläpitää ja edistää terveyttä, ehkäistä ja hoitaa potilaidensa sairauksia sekä lievittää heidän kärsimyksiään. Lääkärin tulee kaikessa toiminnassaan kunnioittaa ihmisyyttä ja elämää.

Lääkärin ei pidä koskaan osallistua kidutukseen, kuolemanrangaistuksen täytäntöönpanoon tai muuhun epäinhimilliseen toimintaan tai sellaisen valmisteluun.

II
Lääkärin tulee käyttäytymisellään ja toiminnallaan ylläpitää lääkärin tehtävän vaatimaa ammattikuntaan kohdistuvaa arvostusta ja luottamusta.

III
Lääkärin tulee kohdella potilaitaan tasa-arvoisina, oikeudenmukaisesti ja syrjimättä.

IV
Lääkärin tulee kunnioittaa potilaan itsemääräämisoikeutta ja tukea potilasta osallistumaan hoitoaan koskevaan päätöksentekoon. Itsemääräämisoikeuden toteutumista on mahdollisuuksien mukaan tuettava silloinkin, kun lääkäri joutuu toimimaan potilaan tahdosta riippumatta.

V
Lääkärin tulee pitää yllä ja kartuttaa tietojaan ja taitojaan. Hänen tulee käyttää ja suositella vain tutkimuksia ja hoitoja, jotka ovat lääketieteellisen tiedon ja kokemuksen perusteella vaikuttavia ja tarkoituksenmukaisia.

VI
Lääkärin tulee edistää tieteenalansa tutkimusta. Lääketieteellisessä tutkimuksessa lääkärin on noudatettava tietoon perustuvan suostumuksen periaatetta ja muita Helsingin julistuksen vaatimuksia.

VII
Lääkärin on noudatettava salassapitovelvollisuutta ja edistettävä myös potilastietojen luottamuksellisuutta.

VIII
Lääkärin tulee hoitaa potilasta tämän avuntarpeen mukaan ja asettaa palkkionsa suoritetun työn perusteella. Lääkäri ei saa tavoitella perusteetonta aineellista etua.

IX
Todistuksia ja lausuntoja antaessaan lääkäri toimii yhteiskunnan hyväksymänä puolueettomana asiantuntijana. Lausunnon on perustuttava huolellisen lääketieteellisen arvioinnin antamiin objektiivisiin havaintoihin sekä niiden ja taustatietojen kriittiseen tarkasteluun.

X
Julkisessa esiintymisessään lääkärin tulee noudattaa tarkkaa harkintaa ja välttää itsensä tarpeetonta korostamista sekä suhtautua potilaaseen kunnioittavasti. Lääkärinä hänen tulee perustaa kannanottonsa lääketieteelliseen tietoon ja kokemukseen.

XI
Lääkärin tulee omalla käytöksellään ja toiminnallaan vaalia ja edistää kollegiaalisuutta potilaan parhaaksi sekä arvonmukaisen hengen ja hyvän toveruuden ylläpitämiseksi.

XII
Lääkärin tulee toimia aktiivisesti niin, että hän voi työssään noudattaa näitä velvollisuuksia ja periaatteita.

APPENDIX 2. Nurses’ Code of Ethics

Text as saved December 30, 2016. Translated by Salla Saxén, followed by the original version in Finnish.

The purpose of the ethical code of conduct is to support nurses, public health nurses, midwives, and paramedics (college level) in the ethical decision-making related their daily work*. The code manifests the basic mission and the principles of work for nurses, other people working in the healthcare section and the public.

* From here on the term nurse is used to signify all people who have graduated as nurses, public health nurses, midwives, and paramedics (college level).

I The nurse’s mission

The nurse’s mission is to advance and uphold the health of the public, prevent illness and alleviate suffering.

The nurse helps people of all ages in different life situations. The nurse serves individuals, families and communities. By taking care of people, she aims to support and advance people’s own assets and to improve their quality of life.

II The nurse and the patient

In her actions, the nurse is primarily responsible to the patients who are dependent on her care. She protects human life and advances the individual wellbeing of the patient. The nurse encounters the patient as a dignified human being and creates a culture of care in which individual values, conviction and habits are taken into account.

The nurse respects the patient’s right to autonomy and creates possibilities for the patient to participate in the decision-making related to her own care. The nurse keeps the confidential information disclosed by the patient in secrecy and reflects upon the question when to discuss them with other people participating in the patient’s care.

The nurse treats another human being as a neighbor. She listens to the patient and empathizes with her situation. The relationship between the nurse and the patient is based on open interaction and mutual trust.

The nurse acts in a just manner in her work. She treats every patient equally well and in relation to the patients' individual need of care, regardless of their health problem, culture, religion, first language, age, gender, race, skin color, political opinion or societal status.

III The nurse's mission and professional skill

The nurse is personally responsible for her work. She evaluates her own and others' competence while taking on duties and giving them to others. The duty of a professional nurse is to continuously advance her professional skills.

Nurses working in the same care community together are responsible for the quality of the treatment and the constant advancement of this quality.

IV The nurse and colleagues

Nurses support each other in patient-related decision-making, having enough strength to do their work and professional development.

Nurses respect their own expertise and the expertise of other professional groups. They aim at good collaboration with the other professionals whose work is related to their patient's care.

The nurses monitor that the other members of their profession and other professional do not act in an unethical manner toward the patient.

V The nurse and society

The nurses participate in societal discussion and decision-making regarding people's health, quality of life and wellbeing on both national and international levels.

The nurse works together with the patient's family and other people close to them and thereby strengthens their participation the patient's care. She gives health-related knowledge for the public and advances people's abilities to take care of themselves. The nurse collaborates with community services as well as disability and patient associations.

The nurses' work on an international level consists of reciprocal communication of professional knowledge and skill as well as participation in the action of international associations. The nurses carry responsibility for the development of the health-related and social living conditions globally as well as the promotion of equality, tolerance, and solidarity.

VI The nurse and the profession

The nursing profession takes care that the members of the profession manage their societal task in a dignified manner. The professional group supports the moral and ethical development of its members and oversees that the profession retains its humane helping duty.

The nurses' professional community takes care of the wellbeing of the members of the group. Their professional organization works actively to ensure just social and economic working conditions for the members of the profession.

The nursing profession is responsible for the expertise of the field. Nurses take care of the deepening of the content of the profession, development of the education, and the advancement of scientific practices. The growth of professional expertise should be reflected in the advancement of wellbeing in the public.

This ethical code of conduct has been accepted in the general assembly of the nurses' union Sairaanhoitajaliitto 28.9.1996.

Original version:

Eettisten ohjeiden tarkoituksena on tukea sairaanhoitajien, terveydenhoitajien, kätilöiden ja ensihoitajien (AMK) eettistä päätöksentekoa heidän päivittäisessä työssään*. Ohjeet ilmaisevat sairaanhoitajille, muille terveydenhuollossa työskenteleville sekä väestölle sairaanhoitajan perustehtävän yhteiskunnassa ja hänen työnsä periaatteet.

* Jatkossa käytetään termiä sairaanhoitaja tarkoittamaan sairaanhoitajan, terveydenhoitajan, kätilön ja ensihoitajan (AMK) tutkinnon suorittaneita.

I Sairaanhoitajan tehtävä

Sairaanhoitajan tehtävänä on väestön terveyden edistäminen ja ylläpitäminen, sairauksien ehkäiseminen sekä kärsimyksen lievittäminen.

Sairaanhoitaja auttaa kaikenikäisiä ihmisiä erilaisissa elämäntilanteissa. Sairaanhoitaja palvelee yksilöitä, perheitä ja yhteisöjä. Ihmisiä hoitaessaan hän pyrkii tukemaan ja lisäämään heidän omia voimavarojaan sekä parantamaan heidän elämänsä laatua.

II Sairaanhoitaja ja potilas

Sairaanhoitaja on toiminnastaan ensisijaisesti vastuussa niille potilaille, jotka tarvitsevat hänen hoitoaan. Hän suojelee ihmiselämää ja edistää potilaan yksilöllistä hyvää oloa. Sairaanhoitaja kohtaa potilaan arvokkaana ihmisenä ja luo hoitokulttuurin, jossa otetaan huomioon yksilön arvot, vakaumus ja tavat.

Sairaanhoitaja kunnioittaa potilaan itsemääräämisoikeutta ja järjestää potilaalle mahdollisuuksia osallistua omaa hoitoaan koskevaan päätöksentekoon. Sairaanhoitaja pitää salassa potilaan antamat luottamukselliset tiedot ja harkitsee, milloin keskustelee niistä muiden hoitoon osallistuvien kanssa.

Sairaanhoitaja kohtelee toista ihmistä lähimmäisenä. Hän kuuntelee potilasta ja eläytyy tämän tilanteeseen. Sairaanhoitajan ja potilaan välinen hoitosuhde perustuu avoimeen vuorovaikutukseen ja keskinäiseen luottamukseen.

Sairaanhoitaja toimii tehtävässään oikeudenmukaisesti. Hän hoitaa jokaista potilasta yhtä hyvin ja kunkin yksilöllisen hoitotarpeen mukaan, riippumatta potilaan terveysongelmasta, kulttuurista, uskonnosta, äidinkielestä, iästä, sukupuolesta, rodusta, ihon väristä, poliittisesta mielipiteestä tai yhteiskunnallisesta asemasta.

III Sairaanhoitajan työ ja ammattitaito

Tekemästään hoitotyöstä sairaanhoitaja vastaa henkilökohtaisesti. Hän arvioi omansa ja muiden pätevyyden ottaessaan itselleen tehtäviä ja jakaessaan niitä muille. Ammatissa toimivan sairaanhoitajan velvollisuutena on jatkuvasti kehittää ammattitaitoaan.

Samassa hoitoyhteisössä työskentelevät sairaanhoitajat vastaavat yhdessä siitä, että hoitotyön laatu on mahdollisimman hyvä ja että sitä parannetaan jatkuvasti.

IV Sairaanhoitaja ja työtoverit

Sairaanhoitajat tukevat toinen toistaan potilaan hoitoa koskevassa päätöksenteossa, työssä jaksamisessa ja ammatillisessa kehittymisessä.

Sairaanhoitajat kunnioittavat oman ja muiden ammattiryhmien edustajien asiantuntemusta. He pyrkivät hyvään yhteistyöhön muiden potilaan hoitoon osallistuvien työntekijöiden kanssa.

Sairaanhoitajat valvovat etteivät oman ammattikunnan jäsenet tai muut potilaan hoitoon osallistuvat toimi potilasta kohtaan epäeettisesti.

V Sairaanhoitaja ja yhteiskunta

Sairaanhoitajat osallistuvat ihmisten terveyttä, elämän laatua ja hyvinvointia koskevaan keskusteluun ja päätöksentekoon sekä kansallisella että kansainvälisellä tasolla.

Sairaanhoitaja toimii yhdessä potilaiden omaisten ja muiden läheisten kanssa ja vahvistaa näiden osallistumista potilaan hoitoon. Hän antaa terveyttä koskevaa tietoa väestölle ja lisää ihmisten kykyjä hoitaa itseään. Sairaanhoitaja tekee yhteistyötä vapaaehtois-, vammais- ja potilasjärjestöjen kanssa.

Sairaanhoitajien kansainvälinen työ on ammatillisen tiedon ja taidon vastavuoroista välittämistä sekä osallistumista kansainvälisten järjestöjen toimintaan. Sairaanhoitajat kantavat vastuuta ihmiskunnan terveydellisten ja sosiaalisten elinolojen kehittämisestä maailmanlaajuisesti sekä edistävät samanarvoisuutta, suvaitsevaisuutta ja yhteisvastuullisuutta.

VI Sairaanhoitaja ja ammattikunta

Sairaanhoitajakunta huolehtii siitä, että ammattikunnan jäsenet hoitavat arvokkaasti yhteiskunnallisen tehtävänsä. Ammattikunta tukee jäsentensä moraalista ja eettistä kehitystä sekä valvoo, että sairaanhoitajalla säilyy ihmisläheinen auttamistehtävä.

Sairaanhoitajat vastaavat ammattikuntana jäsentensä hyvinvoinnista. Heidän ammattijärjestönsä toimii aktiivisesti oikeudenmukaisten sosiaalisten ja taloudellisten työolojen varmistamiseksi jäsenistölle.

Sairaanhoitajakunta vastaa oman alansa asiantuntijuudesta. Sairaanhoitajat huolehtivat ammatin sisällön syventämisestä, koulutuksen kehittämisestä sekä tieteellisyyden edistämisestä. Sairaanhoitajakunnan asiantuntijuuden kasvun tulisi näkyä väestön hyvän olon edistymisenä.

Sairaanhoitajan eettiset ohjeet hyväksytty Sairaanhoitajaliiton liittokokouksessa 28.9.1996.

Articles

ARTICLE I

Saxén, S. 2016. Untangling Uncertainty: A Study of the Discourses Shaping Clinical Ethics Consultation as a Professional Practice. The Journal of Clinical Ethics 27(2): 99–110.

ARTICLE II

Saxén, S. 2018. Same Principles, Different Worlds: A Critical Discourse Analysis of Medical Ethics and Nursing Ethics in Finnish Professional Texts. HEC Forum 30(1): 31–55.

ARTICLE III

Saxén, S. 2018. To Strive Toward Without Reaching: Moral Expertise as a Paradox in Clinical Ethics Consultation. In Watson, J. C. & Guidry-Grimes, L. K. (Eds.) Moral Expertise: New Essays from Theoretical and Clinical Bioethics. Cham: Springer International Publishing.

The original publications were reprinted with the permission of the copyright owners.

ARTICLE I

Saxén, S. 2016. Untangling Uncertainty: A Study of the Discourses Shaping Clinical Ethics Consultation as a Professional Practice. The Journal of Clinical Ethics 27(2): 99–110.

Salla Saxén, "Untangling Uncertainty: A Study of the Discourses Shaping Clinical Ethics Consultation as a Professional Practice," *The Journal of Clinical Ethics* 27, no. 2 (Summer 2016): 99-110.

Features

Untangling Uncertainty: A Study of the Discourses Shaping Clinical Ethics Consultation as a Professional Practice

Salla Saxén

ABSTRACT

This qualitative social scientific interview study delves into the ways in which professional vision is constructed in clinical ethics consultation (CEC). The data consist of 11 semi-structured interviews that were conducted with clinical ethics consultants currently working in hospitals in one major urban area in the U.S. The interviews were analyzed with the qualitative research method of critical discourse analysis, with a focus on identifying the cultural structures of knowledge that shape CEC as a professional practice. The discourses were first identified as belonging to two higher discourse categories, *order* and *agency.* Order was divided into three lower categories, *emotional, managerial,* and *rational* order, and discourses of agency into the lower categories of *exploration, technique, deliberation,* and *distancing.* An additional discourse of neutral interaction was identified as a bridging discourse, activated to level tensions emerging out of conflicting goals and agencies embedded in CEC practice. This analysis brings out as its main observation that clinical ethics consultants draw on and shift between potentially ideologically conflicting social positions that can create built-in tensions within the professional domain. The study calls attention to these tensions and suggests for the professional group to discuss the possibility of defining priorities between different kinds of order, identified in this study, that shape the CEC domain.

Salla Saxén, MSSc, is a Doctoral Candidate at the University of Eastern Finland, Kuopio Campus. *salla.saxen@gmail.com*

INTRODUCTION

Clinical ethics consultation (CEC), or healthcare ethics consultation (HCEC), is a fairly new professional practice in the healthcare field, and it can be described as "a service provided by a committee, team, or individual to address the ethical issues involved in a specific, active clinical case."[1] In the U.S., the field is currently under vivid social struggle, as efforts toward formal professionalization[2] have led to debate within the field about the central definitions of the practice.[3] Such a conflicted situation can be identified as the complex social process called the *internal unification* of a profession, which is a typical phase of professionalization.[4]

The goal of this qualitative social scientific study is—by analyzing interview data—to understand the discourses that shape CEC as a professional practice. The theoretical starting point is based on social constructionism, which presumes that central to the organization of a profession is its ability to shape events in the domain of its scrutiny: to give names and meanings to certain objects of knowledge. Based on this meaning making, a profession is able to organize its discourse around certain phenomenal objects and incorporate them into its realm of inquiry and action.[5]

In this study, I explore what CEC practice marks as significant and thereby incorporates into its realm of inquiry. As the emphasis in this study is put on the exploration of the professional constructions of CEC itself, the individual backgrounds of the interviewees are deliberately not given weight in the analysis. Thus, I start by assuming that despite the fact that people working in the field of CEC come from a variety of backgrounds and often wear more than one hat, there are also shared constructions of what it means to be a clinical ethics consultant: constructions that form the socially circulated—yet also contested—professional vision[6] that shapes and gives meaning to CEC. Professional vision is a useful concept, as it explains why different professions view the same objects or events in different ways, for example, how an archaeologist and a farmer may look at the same patch of dirt and yet see different things.[7] In the same way, I start with the presumption that a certain professional vision of this kind allows a practicing clinical ethics consultant to view everyday hospital life through a specific, meaningful professional lens, to transform the hospital's scattered and scrappy life-world into graspable concepts and tangible action that provide socially constructed meaning, significance, purpose, and legitimation for CEC.

In this article, I refer to CEC as a "professional practice," even though the field is currently officially unacknowledged as a profession. This conceptual choice has been made for the following reasons: as the interviewees were comfortable with the terms *professional* and *profession,* I have chosen not to challenge the concept of professionalism, since, due to the theoretical framework of this study, I approach CEC as a social construction. Thus, it could be said that the use of the term emerges from "bottom up." Moreover, the ongoing endeavor to professionalize the field, in itself, also indicates that, within the field, there is wide movement in which CEC is being constructed as a profession (even though social struggle over the concept no doubt abides). It should also be noted that since I view the professional domain as a social construction arising from the "bottom up," I allow the data to shape what this professional domain encompasses—in other words, I do not limit CEC expertise to cover only definitions of the *consultation* act itself, but to involve all the territory the interviewees have presented to me, including other professional aspirations, such as education and policy writing. It is, however, important to add that by studying CEC as a *professional* practice, I do not intend to adopt any position in the debate on whether the field should be officially acknowledged as a profession or not—taking such a normative stand would go past my domain of inquiry and expertise.

In order to tap into the inner logic of CEC, I analyze interview data to explore the ways in which the domain of practice of CEC is discursively shaped and presented to an outsider listener—to me, a nonclinician social scientist from another country and culture. As the in-depth interview is a personal and intimate encounter that is often used to elicit detailed narratives and stories,[8] it seemed natural that the interviews would allow the ethics consultants to define their professional life and its meanings in their own words. I deliberately chose to study interviews—instead of, for example, official texts or other nonpersonal records—to access the experienced professional life-world in a way that echoed the realities of living in this particular professional domain, with its ups and downs. Additionally, I anticipated my outsider position would enhance the depth of the interviews,[9] as I assumed that the interviewees would explain their profession to me in great detail, since they would not expect me to know the things that their CEC colleagues, for example, would know implicitly. Yet, it should be acknowledged that analyzing the interview data leaves many important aspects of the everyday life of the practice of CEC out of the scope of this study, as the domain of work is not captured "in action," but instead as retrospective narratives. Nevertheless, as professions ultimately only become legitimized by convincing outsiders,[10] it can be argued that *especially* the ways in which a profession represents its domain of expertise to outsiders reflect the main constructions forming the essential "what," "why," and "how" of a profession.

With these presumptions in mind, I explore the essence of what makes CEC meaningful in the personal accounts collected through interviews. What do consultants "see" through their professional lens? What is constructed as significant from this particular perspective? How does the profession respond to what it marks significant? What kind of demands do these ways of "seeing" set for those working as consultants? Do these demands presume ideological orientations? By exploring such ways of professional construction and conceptualization, I aim to create awareness of the subtle social landscape that produces order and meaning in the professional culture of CEC. I also explore the ways the different discourses position ethicists into social roles with different kinds of implicit expectations.

METHOD

To shift the focus on what lays under the surface, it is important to develop a critical eye toward what is on the surface. I follow Eliot Freidson's assertion that what a profession declares itself to be should not be treated by social scientists as a fact, but rather as a form of social organization based on a professional claim of expertise.[11] In the case of CEC, it would be naïve for a social scientist to assume that the profession was comprehensively defined by solely claiming that it consists of "identifying and analyzing the nature of value uncertainty or conflict" or "facilitating resolution of conflicts in a respectful atmosphere," as has been suggested.[12] While I do not doubt the sincerity of this goal, it is still clear that many of the implicit complexities of social reality are rendered invisible by these claims. Such implicit elements that construct the order of social life can only be brought into the light by empirical inquiry, as it presents a way to deconstruct the professional mystique that the claim—itself a source of mystique—cannot capture.

The theoretical approach of this study is based on social constructionism.[13] Viewed from the perspective of this theory of knowledge, professions are understood as cultural constructions that are shaped by discursive practice: structures that are created by a dynamic social process in which specific ways of talking and conceptualizing have become culturally hegemonic. Additionally, while from this perspective professions are understood as *created, negotiated,* and *sustained* via such hegemonizing social and cultural practices, they are also viewed as constrained by the same discursive practice, as the possibilities of seeing and acting are controlled by contingent norms of conduct and thought that set the boundaries for the professional sphere of influence and action.[14]

Metaphorically, one could think of the available professional ways of "seeing" as being like paths in a forest: they provide direction and order for taking steps forward—yet, while providing direction, they also constrain walkers to pass only through certain areas of the forest and disregard areas they cannot see. But at the same time, it should be added that acknowledging there are such paths in social reality—paths that both direct and constrain—does not imply that one could not set out into the wild to make one's own path. Professional discourse is not set in stone, but rather in the flux of being constantly socially renegotiated.[15] In this study I delve into exploring what kinds of "paths" of reasoning and action the professional culture of CEC enfolds. This is a topic that requires conscious exploration, as the paths available are typically not explicitly visible to the people involved. They are, in a way, "hidden," by virtue of being so implicit that they rarely become openly questioned or explained—as if they are hiding out in the open.

With these presumptions, I approach the data using the method of critical discourse analysis (CDA). As the "paths"—prevailing discourses—are typically taken for granted and seen as "common sense," making them visible may uncover many enlightening perspectives on the cultural meanings and ideological underpinnings of CEC. Based on this view, discourse analysts presume that in order for embedded discourses to be exposed and made explicit, the use of language in research data must be carefully scrutinized using qualitative analysis techniques.[16] This data reading method is critical in the sense that it aspires to show connections and causes that are typically not transparent to the people involved in the discourse.[17] Thus, critical discourse analysis does not imply "criticism" of the object of the study, but rather is a technique aimed at exposing hidden cultural constructions and tensions. Second, the study is discourse analytic in the sense that it presumes that language not only reflects or represents social practice, but also constructs it. The method, thus, starts from the presumption that language "produces a social reality that we experience as solid and real."[18] It can be argued that if the discourse did not shape meaning and the structure of thought, there would be no shared conception of social reality. Thus, it becomes evident that to understand reality, our experiences, and ourselves, we should make efforts to understand discourse.[19]

In the literature concerning the CDA approach, the exposing of power imbalance and techniques of dominance are often highlighted, and this is often used as a method to unveil racism, misogyny, or other kinds of marginalization in everyday interaction, as well as in media texts and official records.[20] In this study, I take a slightly more cautious approach to the method, as I do not scrutinize techniques of marginalization in my data but, rather, use the method as a way to create awareness of the general structures of knowledge and action that work together to shape the professional domain of CEC. Based on the CDA method, I view the concept of discourse as structural rather than situational, as reflecting widely circulated systems of knowledge rather than the micro reality of what happens between the interviewee and the interviewer. Yet, the method does not imply a top-down view of discourse, but highlights the importance of struggle. People may position themselves either to align with the identified hegemonies or resist them.[21] Viewing discourse as structural—as a social force shaping practice in certain ways as well as contested—allows the researcher to identify the shaping discourses without implying determinism, and thus leaves room for struggle and further discussion. Showing what kinds of ways of thinking are typical also brings attention to other approaches that appear to be shut out of the scope of the field. Bringing attention to what is "known" as common sense within a field also reveals what is "doubted," and may turn attention to what is left entirely invisible. In this study, I focus on identifying the "known knowns" of the field of CEC, and speculate less on the possibilities of what could be. Yet this study also does aim at awakening discussion of both what is and what could be by opening up a perspective on the politics of professional knowing.

The data consist of 11 semi-structured interviews that vary between 45 and 100 minutes in length, which were collected in one major urban area (five hospitals in total) in the U.S. in the time period between October 2014 and May 2015. All the interviewees were reached through a central contact person located in a university-based bioethics center. The bioethics center was a natural place to start making connections, as the main purpose of the center is to enhance and sustain inter-hospital connections and communication as to bioethical topics. The interviewees were interviewed in their own offices (n = 5), in general hospital meeting rooms (n = 3), and in general university meeting rooms (n = 3). The backgrounds of the interviewees were physicians (n = 2), nurses (n = 5), other clinical professionals (n = 3), and one lawyer. As the focus of the study is on the inner logic of the statements and not on the interactional order of the situation in which the statements were made, the interviews were transcribed in a way that did not pay close attention to the microstructure of the speech, but rather recorded it in the simplest possible way, with the exception that extended pauses, whispering, laughter, as well as laughing tone were recorded on the transcription. In total, the transcriptions add up to 148 single-spaced pages. To protect the identities of the interviewees, all data samples are anonymized. For the same reason, I have also chosen not to expose the name of the city in which the interviews were made, as CEC is a relatively small profession, and identification might be possible by location.

I approached the data by first making the assumption that some kind of implicit cultural net of silent assumptions exist in it, and that the workings of these implicit orientations can be scrutinized by paying attention to what is present in the data but not said out loud. The first phase of the analytical reading was aimed at developing intuitions in the data: simply reading the data and listening to the audio records in a state of wonder as to what is going to emerge. After this, a more systematic way of reading was adopted, one in which I identified certain themes that appeared to repeat themselves in the data and wrote them down with illustrative data samples. In doing this, I paid attention to the levels of explicit explanation and justification in what was said. As certain statements required less explicit explanations, I paid more attention to questioning what kind of assumptions gave them their unquestionable nature. I also asked what kinds of categories could be actualized, not only in specific examples, but in a variety of different kinds of situations and settings.

The third phase was testing of the categories developed by iterative reading of the data. In this phase the initial categories often needed to be modified or rejected altogether. This testing and redeveloping of the categories illustrates well how the steps of the analysis phase did not simply progress, but often went back and forth between the mentioned phases. This analysis process also shows how categorization emerges out of the data-reading phase in a way that is typical for qualitative research, in which categories of inquiry are not isolated and defined before the data collection, but instead the categorization occurs during the analysis phase of the study.[22] Yet, there are no coherent rules of how such analysis should be made, and, in the end, this depends largely on the imagination of the researcher. In such a process, what is being asked of the data, and how the data are methodologically being approached, makes all the difference in defining what can be found—and even still, not every researcher would come to the same conclusions with the same questions and methods. Eventually, the greatest test to which the analysis can be put lies outside the scope of the researcher; that is, whether or not the findings resonate with the people whom the study addresses.

FINDINGS

The field of CEC as a professional practice was identified as constructed by two higher categories of discourse: order and agency. Order was divided into three lower categories, *emotional, managerial,* and *rational* order, and discourses of agency into the lower categories of *exploration, technique, deliberation,* and *distancing.* An additional discourse of *neutral interaction* was identified as a bridging discourse that was activated to level tensions created by the ambiguity and conflicted goals of other discourses. All of these discourses appear in the data, yet in different variations. I assume this variation to reflect the heterogeneous backgrounds of the interviewees, as well as the diverse institutional microcultures of the hospitals.

When presenting analysis, I include data samples selected from the interview data. It should be noted that the method of critical discourse analysis does not present any systematic approach to selecting data samples—I have simply chosen them based on my own considerations. The role of quotations is to illustrate how the discourse appears in everyday language, and thus, the quotes demonstrate how the findings of this study are grounded in everyday life. The illustrating data samples also attempt to prompt the imaginations of readers, to identify similar ways of making sense of CEC in their own experiences.

In choosing the quotations, I have paid attention to selecting easily understandable statements that follow the logic of the identified discourses. This is not to claim these exact quotations would be any better than other possible quotations, only that I have chosen them because they illustrate the ways in which the discourses identified here appear in everyday talk. Some of the quoted statements include ellipses to improve their clarity. To offer good examples of the discourses in a nutshell, I have deleted some parts of the quotations—such as repetition, listings of who was present and where, or other details—that do not add essential value to illustrating the inner logic of the discourses I present.

Working Toward Order

The discursive category of order points to the objectives of the professional domain, that is, the questions relating to what is being pursued with CEC. In general, the rationale for CEC was identified in this study as an attempt to create order in the gray areas of healthcare in which uncertainty is unavoidable. These gray areas are the typically invisible links through which the social realities of medical care meets philosophy: How to define what is right? Whose point of view counts? Why? In the interviews, this elusive world of uncertainty represents something that inescapably “bubbles up.” I have interpreted these “bubbles” to represent the occasions in which a rupture is suddenly and unexpectedly confronted in the established social order—and when order is ruptured, disorder emerges. Without disorder, the goal of order would remain empty; the realm of CEC becomes meaningful only when disorder bubbles up, for example:

> We don’t often even notice the questions of ethics until they’re, I’m gonna call it a bump in the road. The bump in the road is about uncertainty, or it’s about conflict. [Interviewee 7]

I have identified three kinds of discourses of order to define CEC practice: managerial, emotional, and rational order. These discourses of order respond to different kinds of constructions of disorder.

Managerial order. A modern hospital is a complex institution that has to be managed socially and economically—otherwise it will not function. A clinical ethics consultant is typically hired by the hospital and held accountable for CEC. Therefore it is only natural that at least part of the CEC work is shaped by demands or aspirations to participate in managing the life in the hospital. For example, the avoidance of lawsuits, with the help of CEC, in order to benefit the hospital is mentioned frequently in the interview data. From this point of view, CEC becomes legitimized and meaningful by serving the managerial order of the hospital. It functions as a mechanism to ease conflicts that may be at risk of becoming detrimental to the hospital organization:

> Ethicists can really help to try to listen to each party but then find a solution that’s towards the middle that all parties can live with. [. . .] Ultimately when it’s not possible, and you have an intractable dispute, that’s often when it goes into the legal realm. So that’s, that’s obviously what we want to avoid. [Interviewee 11]

In this data sample, the “ethics realm” and the “legal realm” appear as if placed on a continuum that is defined by the troublesomeness of the dispute. Avoiding conflicts that lead to the legal realm is presented as something that it is “obvious” to want to avoid. The ethicist is, thus, implicitly positioned as an agent who can level disputes as a way of keeping the hospital organization out of legal trouble. In the following sample, ethics consultation also appears as something that can be considered useful in and by itself for the potential legal process:

> A lot of times when they [physicians and nurses] are feeling worried about being sued they consult, because they wanna have an ethical note in the record. [Interviewee 3]

In this data sample, ethics consultation is represented as a “note in the record,” which implies that CEC can have strategic significance that cannot be reduced simply to the results of a consultation—and that this strategic piece of influence fits the interests of defending hospital staff, should they be sued. In such subtle ways, the ethics consultant is positioned into playing a strategic role in sustaining the managerial order of the hospital organization.

Emotional order. In the interviews, many descriptions emerged in which the role of the ethics consultant was defined as that of supporting healthcare staff in ways that could loosely be placed under the category of "emotional." Based on these descriptions, I have identified the discourse of emotional order, by which I refer to the ethics consultant's role in the management of the emotional landscape of the hospital. For example, CEC is repeatedly defined as a pursuit to ease distress, in which the consultant is positioned as a competent agent to achieve this end:

> I feel a strong desire to assist the doctors and the nurses because they do experience a lot of distress about some of these cases [. . .] I feel a desire to help them cope with that so they can continue doing the amazing work that they do and not get overcome with feelings of, just, um, discouragement or moral distress. [. . .] When we do our rounds and are checking with them, it sort of gives them an opportunity to express their, their feelings and kind of vent about, cases where they feel very conflicted. [Interviewee 11]

In this discourse, the emotional realm of hospital working life is produced as a potential source of disorder—even so much that without the ethicists, the healthcare providers are portrayed as possibly not capable of continuing to do their work. Thus, interventions—such as ethics rounds—to restore function and order in the emotional landscape enter the agenda of the clinical ethicist. This points to the implicit assumption that the healthcare work domain is not "only work" in a detached rational sense, but rather involves deep psychological absorption and emotional commitment on the part of the healthcare providers. Emotional life crosses the lines between "work selves" and "private selves." The role of the ethicist in this order is to act as a mediator, a "vent" through which the emotions can come out safely without disrupting the social balance and order of hospital work life. This discourse thus positions the ethicist as a resource of staff support. At the same time, it should be noted that while an ethicist could potentially also be presented as an agent of alleviating patients' distress in the same way, this goal did, interestingly, not appear very clearly in my data. As a consequence, this role may potentially position ethicists into a role with understandable, built-in tensions if they are implicitly expected to solely support the staff in disputes with patients when difficult decisions are being made.

Rational order. In the discourse I have named rational order, the ethics consultant is represented as having the ability to provide rational models to support and sustain best ethical practices in everyday hospital life. In this discourse, identifying ethically problematic areas, as well transforming them into rational systematic policies, methods, and actions, appears on the agenda of the ethics consultant. This approach presupposes that social life in the hospital conceals many unanswered and difficult ethical questions; the ethics consultant is positioned to be on an exploration to expose such challenges as well as to offer intelligible solutions and education concerning them:

> I would say that we do a lot more preventive ethics work, with our educational seminars, through identifying very common types of issues [. . .]. So we do a lot of education, we have lately been working on developing [. . .] our ethics resources [. . .] sort of quick-and-dirty ways to, to think about, those kinds of things. [Interviewee 1]

With the same logic of presenting ethicists as agents of rational thinking, they are defined as "ethics translators," persons who can interpret vague feelings and qualms and convert them into the intellectual language of ethics. Through this translation work, such ambiguous experiences become reframed, and thus, ordered by rational thought. This rational language offers a solid ground to face and deconstruct issues in the gray areas where uncertainty, ambiguous emotions, and conflicts abide:

> It can be a pretty simple case but you can pinpoint two or three ethical issues, you kind of see that light bulb go on where they'll go, oh wow, I never thought of it like that. [. . .] You can see people go, oh so that's what the ethics concern is. They know something is not right, but they, they might not know to label it as an ethical concern. [Interviewee 4]

As "ethics translators," ethics consultants appear as knowledgeable and practical professionals with the capacity to untangle the social and emotional knots bubbling out of everyday interaction. Thus, consultants are not distant experts available only for resolving ethically complex patient cases or in their ivory tower writing policy recommendations, but rather grass-root-level intermediators who can identify difficult and contentious issues in everyday life and then bring them to a higher level of abstraction, in which recreating order becomes possible by developing and utilizing systematic elucidations and solutions. This role then positions ethicists between the practical and the abstract. An implicit assumption defining this role appears to be a characteristic enlightenment narrative. Turning ambiguous everyday life into rational concepts can "give light" and help in the ordering of everyday action—while the alternative is darkness:

> So that there can be standards, so that there's not relativism, so that we use the literature to tell us, you know, what, what does this look like, or else we are sort of, just feeling in the dark. [Interviewee 1]

Professional Agency

If order refers to what CEC as a professional practice aims to accomplish, agency correspondingly refers to the types of discourse that shape the means of how order can be pursued. I have identified four discourses of professional agency: technique, exploration, deliberation, and distancing.

Working by technique. The discourse of agency as a technique is best defined by the metaphor of a tool box. It points to practical elements that can be taught and learned as well as transferred from one situation to another. Such practical tools are, for example, understanding ethical principles as well as the cultural and legal contexts, and the tools of managing communicational interaction by the mastering of mediation and facilitation skills:

> If you think of ethics consultation as having a tool kit, then, mediation is the huge wrench, and those skills can be learned through mediation programs. [Interviewee 7]

The discourse of technique creates agency and offers professional legitimation for CEC, based on the mastery of needed skills. As a consequence, technique binds clinical ethical reasoning into an expert territory, where learnt conceptual reasoning and skills pave the way for CEC practice:

> So I'd say that I bring, personally, having trained, in multiple ways, that I, I'm balancing three different strains of thought. One is the principles, autonomy, beneficence, nonmaleficence and, and justice and fairness of thinking about a process. The second is virtues, taking up virtues and vices and realizing that, conflict can bring out the worst of people, um, but it can also inspire people to bring out their best. [. . .] And then the um, part of that also is, I'd say, part of that psycho-social-spiritual model, because we recognize that there are, deep social needs, and spiritual needs, that might need to be attended. [Interviewee 9]

In this data sample, the ethicist portrays expertise as flowing out of balancing abstract strains of thought that require specific ethics training. In this discourse, both the ability to provide ethics consultation, as well as the right to merit legitimation for it, are located in what seems like a relatively fixed range of technical requirements for the consultant to master.

CEC as exploration. Unlike the technique of agency, the technique of exploration starts from a presumption that not all problems can be solved with the available technical solutions and models. Thus, when viewing the role of the ethics consultant within the discourse of exploration, reality appears to be more complex than was implied by the technique of agency. Rather than leaning only on technical skills, the world is explored with an open mind, which can lead to unexpected discoveries. This exploration starts from the assumption that ethicists set out to find out something they do not yet know. The discourse of ethicists as explorers abandons the idea that ethicists can have answers and solutions ready in their tool box at a given time, or that those could be taught or mastered in an impervious sort of way. Exploration thus emphasizes that solutions must be actively sought, and creates discursive space for real uncertainty, which the technique may render invisible by presuming that consultants can grasp any difficult situation by using their tool box:

> The case that haunts me. . . . [. . .] That was a case that I talked to about with people in London, who had been working with *déjà-vu* patients.[23] They also ended up, they said they hadn't had real success either, but we did try some of the directions that they had talked about. [Interviewee 8]

Exploration can also be invoked by the notion of "keeping moral spaces open":[24]

> I just go up in the unit and I say, are you ethically quiet, versus medically quiet. [. . .] It's just a very neutral, nonjudgmental way of saying, are there any ethical issues in the horizon that you wanna talk about. [Interviewee 8]

> Something like ethics rounds certainly are not a requirement but I find them to be a very valuable resource, in quotes "keeping moral spaces open" and really engaging clinicians right at the frontlines where they're taking care of patients um, to um, support, um, their rational processes, um, of emotionally charged situations. [Interviewee 9]

In these examples, the ethics consultant explores with the caregivers what their potential concerns are, in order to establish a communicative climate in which the emotional and ethical domains of healthcare have room to be acknowledged. The latter example also shows how the categories of rational and emotional order are overlapping in the effort of offering constructing support for the healthcare staff.

Deliberation. In the agency discourse I call deliberation, the field of CEC becomes occupied not only by ethicists themselves, but a group of deliberators who aim to collectively construct and share decisions, as well as solutions. In this discourse, the agency to define the meanings and the limits of what is ethical is diversified, and the work of the ethicist is brought under collective scrutiny:

> Whenever we do an ethics consult and write a report, afterwards they [the ethics committee] have access to the report, and we have an open meeting where they've read the report ahead of time and they're able to ask questions about the process that we used, or um the reasoning that we used, or why we, why we didn't do a certain thing, so it's really an opportunity that holds us accountable as ethicists. [Interviewee 11]

The discourse of deliberation brings the scope of the CEC from the individual domain into the sphere of the collective. While the agencies of technique and exploration presuppose ethicists as individually competent professionals, capable of conducting worthy practice, the discourse of deliberation presupposes that CEC work is, by nature, political, or at least vulnerable to individual biases. This presupposition creates an orientation toward deliberation as a form of checks and balances for evaluating ethicists' work. Yet, tensions may rise in defining the borders of the individual and collective domains of practice: how to define the borderlines between what kinds of decisions or actions ought to be deliberated, and, on the other hand, when to rely on ethicists' individual expertise?

Distancing. The agency discourse that I call distancing refers to the construction of a strategic outsider position as an operational method that is available to ethics consultants. For ethics consultants, there is a potential to position oneself as detached from ongoing social interactions and silent normative frameworks. In distancing, ethics consultants are depicted as those who are wise enough to know what is "really going on," fully aware of the underlying implications present in a situation, and respected enough by others to express that knowledge.[25] This outsider position offers discursive space for ethics consultants that other participants are assumed to lack; for example, in the following example, distancing allows the ethicist to break and reframe the social order in a situation by "stating the obvious":

> One thing that I find helpful is to go ahead and state the obvious. Because, and I think of it as transparent communication, so when everyone's thinking . . . well, this person just doesn't value the other person's idea, that needs to be out on the table. So I will frequently be the person that says you know, maybe I am instigating here, but are you trying to say that you don't respect their beliefs. [Interviewee 4]

In this example, the interviewee implicitly positions the ethicist as an outsider who is not constrained by the social order of the situation in which "the obvious" cannot be stated by others who are entangled in the interaction. Distancing from this social framework grants the ethicist the discursive space to state the obvious. This reframes the situation by enhancing transparency in the attitudes and social positions of the participants.

The strategic positioning of an ethicist as an outsider interventionist can also create social order in and by itself, as the following example demonstrates:

> And the other thing is when they have meetings, they . . . will kind of bark at each other, but the minute you have a, a sort of a neutral person coming in, everybody behaves themselves. It's just like a family. [Interviewee 8]

Distancing can thus serve as a valuable strategy for interventions both by explicitly intervening in the interaction order (first example) and implicitly by virtue of being an outsider (second example), as it offers ways to reframe social situations. Both implicitly and explicitly positioning oneself as an outsider thus holds functional potential for the ethicist to use positioning as a way of untangling conflict and reframing communication.

Neutral Interaction as a Bridging Discourse

The discourses identified in this study deconstruct the social constructions shaping CEC as a professional practice in order to make sense of the different discursive positions available for ethicists in their professional role. These positions assume different expectations: depending on whether ethicists position themselves as a strategic piece of sustaining managerial order, an emotional resource for staff, or an agent of "giving light" through processes of rationalizing everyday events, the goals they will pursue will likely be different. Furthermore, expertise and deliberation as starting points for agency hold different ideological foundations: while deliberation places moral understanding under the collective domain, the technique presumes that specific education can provide a legitimate base for CEC. Depending on the many aspects of the case at hand, these goals and presumptions embedded in the professional discursive landscape may present conflicting implications. How do ethicists navigate between different goals and agencies? What kinds of goals and means should they prioritize, in what situations, and why? Asking such questions explicitly renders the built-in tensions between the different goals of the professional domain visible.

I have identified the discourse of neutral interaction as a bridging discourse that has the potential to alleviate tensions that arise when ethicists need to navigate between the different kinds of order and agency. In the following example, tension can be detected between the agency through which the ethicist appears as an individual expert, and the collective agency of deliberation. This tension in expectations is soothed by the claim that CEC is merely a neutral, consensus building process:

> I think our service is very widely accepted here, but one reason may be that we, we don't walk into the situation and say, well we're the experts we'll just tell you what to do, you know it's a more of a consensus building process. [Interviewee 10]

In this example, entering a situation and claiming expertise is portrayed as clearly negative. The neutral process of consensus building legitimizes the ethicist's entrance into a situation as acceptable by describing the intervention of the ethicist in terms of pure *interaction,* however, it renders the *moral-political domain* of the ethicist's work invisible. It also leaves unanswered whether "ethics" implies "consensus." Yet what this discourse clearly does do is position ethics consultants as experts in enhancing interactions:

> So, when I ask for a cardiac consult, I get a cardiologist who will evaluate like, the patient's heart function and tell me what I should do about it. [. . .] That's not how ethics consultation works. The expertise isn't in the answer, really, the expertise is in the process. [Interviewee 7]

In my data, the enhancement of interaction repeatedly appears as a justifiable and defensible product of CEC, whereas the concept of "ethics expertise" is seen as questionable. My understanding is that if the implicit moral-political domain in which ethicists operate cannot be explicitly discussed and brought to light in the same way as the interactional domain, this indicates that an invisible struggle regarding the definition, limits, and legitimization of CEC underlies my data in silent ways. Moreover, built-in tensions between the domains of order that the professional discourse constructs as significant can be alleviated by claiming neutral interaction. When only neutral interaction is at stake, ethics consultants do not have to face difficult questions as to whether they prioritize working as a strategic piece toward avoiding lawsuits (managerial order), as emotional support persons for staff (emotional order), or in pursuit of finding and entrenching the best ethical practices grounded in conscious exploration and rational reasoning (rational order). It also strategically leaves open the difficult and politically charged question of whose agents ethicists are:[26] whether they work in the interest of patients, the staff, or the hospital institution in general. Additionally, the discourse of neutral interaction eliminates markers of hierarchy and power asymmetry, which may have invisible consequences. Arguably, as overt markers of hierarchy become less evident, covert markers of power asymmetry may become more potent by making power asymmetry more subtle, rather than disappearing.[27]

DISCUSSION

This study describes the ways in which clinical ethics consultants play a part in sustaining different kinds of conceptions of order by taking on an intricate array of social positions in their hospital work field. These positions contain different kinds of meanings and expectations, as well as different agencies, placing ethicists into potentially conflicting and ambiguous social roles. Through the analytical deconstruction made in this study, some of the built-in and silent tension points created by these intersecting demands have been made visible. Such tension points are built-in because they lie in-between the ideologies that the different discourses represent, such as in tensions between individual versus collective forms of agency, or the different conceptions of order. In some of the tension points, the discourse of neutral interaction can be invoked to defend and legitimize CEC practice: by claiming CEC practice is simply about neutral communication, the built-in tensions as well as the pressures created by outside demands can be alleviated. By this perception I do not mean to claim that CEC was not about neutral communication by nature, as the data show no proof to make such an argument. Rather, I merely bring out the observation that neutral communication, as a discursive strategy, can serve as a bridge between the inner tensions that emerge from the ambiguous positions that ethicists take on, as well as from the social realities of the struggle in which they navigate. It should also be noted that it is possible that this bridging effect may hide some tension points from further scrutiny.

As a consequence of the analysis made, the question arises as to what is the first and foremost aspiration defining the practice of CEC—should ethicists put the most weight on enhancing managerial, emotional, or rational order in their work? In this study, I have not made interpretations of the hierarchy of the different levels of order—yet, clearly, in reality, ethics consultants must move flexibly between these conceptions of order, and likely, sometimes channel their energy into helping to recreate one kind of order and overlook another. While I do not make normative statements about what kind of order would be most preferred, I hope that the categorization made in this study can potentially help to conceptualize the choices that ethics consultants confront in their daily working life as they move between different professional aspirations—making the potentially conflicting demands and positions observable and concrete. Creating collective awareness and reflection about the ways in which ethicists navigate between different goals and agencies can also pave the way for the group, as a profession, to define clear normative statements about what kind of order would be regarded as highest in priority, should the varying orders clash.

Given that for practical reasons the interviews were made in only one urban area, it should be acknowledged as a limitation of this study that the data may reflect a local culture, and it is likely that the results would not be the same elsewhere. Yet I do not hold this limitation to be a restriction of a study of this kind, in which the purpose of identifying some discursive practices that construct the professional vision—not all of them—is to serve a larger goal: the stirring up of imagination that gives fuel to further reflection and discussion by bringing explicit attention to the discursive nature of the professional domain. For this same reason, I do not view the relatively small data sample as an obstacle, but rather as an opportunity to offer the researcher the possibility to read the data more closely. Hence I believe the interpretation of this data makes up in idiographic depth what it may lack in volume. Moreover, the 11 interviews show clear repetition of the central themes and ideas that I have identified in my interpretation, which points to data saturation.

When considering the limitations of this study, it should be noted that while this study has demonstrated that the field of CEC conceals a multifaceted canvas of available constructions of order and agency, it does not reveal in what ways these agencies and conceptions of order are actually experienced in ethics consultants' everyday work. Interview data do not reach the ways in which this practice is situated, and the data do not answer in what ways the categories I have listed in this study may directly or indirectly connect to everyday practice.[28] Additionally, the discourses identified in this study naturally do not reflect all of the possible ways of reasoning and understanding surrounding the professional culture of CEC. Rather, the study delves into analyzing those ways that are most clearly represented in limited data. For example, as the perspectives of patients do not appear in the data, I was not able to analyze the practice of CEC in this regard. Moreover, as I have deliberately chosen to study CEC as a professional practice, rather than, for example, as a lay movement,[29] implicit limits have been set as to what can be discovered. Yet, what this study does offer is the development of a systematic categorization of some of the ways that knowledge and perception are framed by discourses of order and agency in the practice of CEC. This categorization can provide a framework that can help CEC professionals, as well as the professional group at large, to reflect on their daily professional experiences, methods and aspirations, while identifying possible points of built-in tension. This categorization can also offer baseline conceptualizations that are potentially useful for the kind of ethnographic research that could further capture the implicit realities of everyday working life—only research of this kind could ultimately expose the ways in which the categories I have identified are translated into action.

To summarize, my perception is that the field of CEC could best be characterized by the notions of fluidity and struggle. A clinical ethics consultant must adapt to be able to fluidity move between the different categories of order, as well as to adapt to different models of agency situationally. Struggle, on the other hand, is the lifeblood of CEC, as it is a field that provides guidance for difficult situations of conflict and other social ruptures. Further, CEC not only faces struggle on the outside, but also on the inside, as its meanings and methods are under constant negotiation. Thus, clinical ethics consultants must learn to live with uncertainty and fluidity in many overlapping ways. While the idea that the social world consists of many areas in which struggle, competing values, and intersecting ideologies abide should come as no surprise to ethics consultants, it is a question of its own whether the field is able to tolerate such pluralism in its own ranks—a question that, at least implicitly, is currently being confronted within the professionalization debate. My hope is only that, in this dispute, CEC professionals exercise endurance in tolerating the struggle, fluidity, and uncertainties they already confront in their daily work.

HUMAN RESEARCH INFORMATION

This article is part of a doctoral thesis that explores different ways of dealing with ethically sensitive issues in healthcare environments, with a central focus on the Finnish healthcare system. The thesis, as a whole, was evaluated by the University of Eastern Finland Committee Research Ethics in June 2014.

ACKNOWLEDGMENTS

My thesis supervisor, Professor Vilma Hänninen, University of Eastern Finland, has provided guidance and support in the writing process. Financial support for writing this article as well as the author's work in general has been received from independent, nonprofit foundations based in Finland: the Finnish Concordia Fund, the Niilo Helander Foundation, and the Emil Aaltonen Foundation.

I would like to thank the executive director of a bioethics program who played a key role in connecting me with the informants, and thus in making the gather of data possible, who must remain anonymous to ensure the anonymization of my data.

CONFLICTS OF INTEREST

The author has no conflicts of interest to report.

NOTES

1. J.A. Tulsky and E. Fox, "Evaluating Ethics Consultation: Framing the Questions," *The Journal of Clinical Ethics* 7, no. 2 (Summer 1996): 109-15, 112.

2. Regarding the professionalization efforts by the American Society for Bioethics and Humanities, see K. Kipnis, "The Certified Ethics Consultant," *HEC Forum* 21, no. 30 (2009): 249-61.

3. The debate is briefly acknowledged in A.J. Tarzian, "A Code of Ethics for Healthcare Ethics Consultants: Journey to the Present and Implications of the Field," *American Journal of Bioethics* 15, no. 5 (2015): 38-51, 38.

4. "Conflict and struggle around who shall be included or excluded mark the process of internal unification of a profession." L.M. Larson, *The Rise of Professionalism: A Sociological Analysis* (Berkeley, Calif.: University of California Press, 1971), xii.

5. C. Goodwin, "Professional vision," *American Anthropologist* 96, no. 3 (1994): 606-33, 628.

6. Ibid., 606.

7. Ibid.

8. B. Dicicco-Bloom and B.F. Crabtree, "The qualitative research interview," *Medical Education* 40, no. 4 (2006): 314-21, 317.

9. C. Tinker and N. Armstrong, "From the Outside Looking In: How an Awareness of Difference Can Benefit the Qualitative Research Process," *Qualitative Report* 13, no. 1 (2008): 53-60.

10. E. Freidson, *Professional Powers: A Study of the Institutionalization of Formal Knowledge* (Chicago: University of Chicago Press, 1986).

11. E. Freidson, *Profession of Medicine: A Study of the Sociology of Applied Knowledge*, 2nd ed. (Chicago,: University of Chicago Press, 1988).

12. American Society for Bioethics and Humanities, *Core Competencies for Healthcare Ethics Consultation,* 2nd ed. (Glenview, Ill.: ASBH, 2011), 3.

13. Social constructionism is a theory of knowledge in social sciences that presupposes that everything that passes for knowledge in society is constituted through social processes in which certain ways of knowing become understood as "common sense." The empirical research in this tradition presumes that the established ways of conceptualizing the truth can be uncovered and brought under critical scrutiny through qualitative inquiry. See P. Berger and T. Luckmann, *The Social Construction of Reality: A Treatise in the Sociology of Knowledge* (New York: Penguin Books, 1966); see also V. Burr, *Social Constructionism* (Abingdon-on-Thames, U.K.: Routledge, 1995).

14. About how discourse shapes professions and their legitimation, see S. Sarangi and C. Roberts, "The Dynamics of Interactional and Institutional Order in Work-Related Settings," in *Talk, Work and Institutional Order: Discourse in Medical, Mediation and Management* Settings (Berlin: Mouton de Gryter, 1999), 1-57.

15. A dialectical perspective to discourse presumes that while discourses have structural ideological influence, they are also always under struggle, and thus, hegemonic knowledge structures manifest only a temporary, partial, and contradictory fixity. N. Fairclough, *Discourse and Social Change* (Cambridge, U.K.: Polity Press, 1992), 66.

16. Ibid.; N. Fairclough, *Language and Power,* 2nd ed. (Harlow, U.K.: Longman, 2001); J. Blommaert and C. Bulcaen, "Critical Discourse Analysis," *Annual Review of Anthropology* 29 (2000): 447-66.

17. Fairclough, *Discourse and Social Change,* see note 15 above, p. 9.

18. N. Phillips and C. Hardy, *Discourse Analysis: Investigating Processes of Social Construction* (Thousand Oaks, Calif.: Sage, 2002), 2.

19. Ibid.

20. Fairclough, *Language and Power,* see note 16 above; T.A. Van Dijk, *Prejudice in Discourse* (Amsterdam: John Benjamins, 1984).

21. Fairclough, *Discourse and Social Change,* see note

15 above, p. 9.

22. G. McCracken, *The Long Interview* (London: Sage, 1988), 16-7.

23. The interviewee refers to a patient who post-operationally developed a nonstop feeling of *déjà-vu*—whatever he did or saw, he always felt that he had experienced it before. The feeling drove the patient crazy, and as morphine seemed to be the only way to quiet his symptoms, difficult ethical questions arose.

24. Quoting M.U. Walker, “Keeping Moral Space Open: New Images of Ethics Consulting,” *Hastings Center Report* 23, no. 2 (1993): 33-40.

25. Compare to similar observation in professional engineering culture made by G. Kunda, *Engineering Culture: Control and Commitment in a High-Tech Corporation* (Philadelphia: Temple University Press, 1992), 178.

26. About the ambiguity in defining whose agent the clinical ethics consultant is, see S. Latham, “Professionalization of Clinical Ethics Consultation: Defining down the Code,” *American Journal of Bioethics* 15, no. 5 (2015): 54-6.

27. About subtle power asymmetry in institutional discourse, see Fairclough, *Discourse and Social Change,* see note 15 above, pp. 202-4.

28. See S. Sarangi, “The Conditions and Consequences of Professional Discourse Studies,” *Journal of Applied Linguistics* 2, no. 3 (2005): 371-94.

29. About clinical ethics consultation as a lay movement, for example, see D. Rothman, *Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making* (New York: Basic Books, 1991); and A. Dzur, *Democratic Professionalism: Citizen Participation and the Reconstruction of Professional Ethics* (University Park, Pa.: Penn State University Press, 2008): 207-43.

ARTICLE II

Saxén, S. 2018. Same Principles, Different Worlds: A Critical Discourse Analysis of Medical Ethics and Nursing Ethics in Finnish Professional Texts. HEC Forum 30(1): 31–55.

HEC Forum
DOI 10.1007/s10730-017-9329-0

Same Principles, Different Worlds: A Critical Discourse Analysis of Medical Ethics and Nursing Ethics in Finnish Professional Texts

Salla Saxén[1,2]

Abstract This qualitative social scientific study explores professional texts of healthcare ethics to understand the ways in which ethical professionalism in medicine and nursing are culturally constructed in Finland. Two books in ethics, published by Finnish national professional organizations—one for nurses and one for physicians—were analyzed with the method of critical discourse analysis. Codes of ethics for each profession were also scrutinized. Analysis of the texts sought to reveal what is taken for granted in the texts as well as to speculate what appeared to be relegated to the margins of the texts or left entirely invisible. Physicians' ethics was discovered to emphasize *objectivity* and *strong group membership* as a basis for ethical professionalism. The discourses identified in the physicians' ethics guidebook were *universal ethics*, *reductionism*, *non-subjectivity*, and *threat*. Nursing ethics was discovered to highlight *reflectivity* as its central focus. This idea of reflectivity was echoed in the identified discourses: *local ethics*, *enlightenment*, and *moral agency*. The analysis exposes a cultural gap between the ethics discourses of medicine and nursing. More work is needed to bridge ethics discourses in Finland in a way that can support healthcare professionals to find common ground and to foster inclusivity in ethical dialogue. Further development of bioethical practices is suggested as a potential way forward.

Keywords Professional ethics · Bioethics · Medical ethics · Nursing ethics · Qualitative research · Critical discourse analysis

---

✉ Salla Saxén
salla.saxen@gmail.com

[1] University of Eastern Finland, Kuopio Campus, Kuopio, Finland

[2] Present Address: Sammonkatu 43 C 36, 33540 Tampere, Finland

Introduction

This qualitative, social scientific study seeks to explore and reflect on the ways in which professional ethics is culturally constructed from two different professional standpoints, nursing and medicine, in Finnish professional texts. Even though both nursing and medicine have traditions of substantial literature and research in professional ethics, little inquiry has been made as to how these professional guidelines appear next to each other. As an outsider to both nursing and medicine—a social scientist—I became interested in exploring what ways professional discourse concerning ethics and values is culturally constructed from these two professional viewpoints, and in what ways these discourses possibly differ from each other. Despite the obvious, technical differences between the two professions, as to ethics and values, I initially assumed medicine and nursing to have more in common than differences. After all, patients are similarly reaching for help from both healthcare professions, and both professions aim at doing their best for helping the patient with their professional skill sets, often also working side by side with each other in similar surroundings. An interesting research question for qualitative inquiry became, thus, to explore in depth what is made culturally relevant to ethics in the professional ethics writings of these two professions.

The central focus of the study is on the analysis of professional ethics guidebooks, one book for each profession. The physicians' ethics guidebook analyzed has been published in 2013 by the Finnish Medical Association[1] (Saarni et al. 2013) and the nursing ethics guidebook in 2012 by the Finnish Nurses Association[2] (Ranta 2012). I chose these particular two texts because the years of publication are close to each other, and because both are published by a professional organization for professional use, and not for example, by a university or an independent publisher. Furthermore, codes of ethics for each profession were also scrutinized in order to create a reflective surface for the analysis of the guidebooks.

In many places, and especially in the US, the past few decades have witnessed a significant change in the ways the nature of ethics is understood in the routine context of health care (Jonsen 1998). By this cultural turn, physicians' once practically total authority over the moral issues of medicine has been widely questioned (Rothman 1991), and as a consequence, the practices of ethical decision-making in the clinics and hospitals has been transformed into a socially complex mosaic consisting of many types of ethics committees, ethics consultants, and other forms of interprofessional practices (about different practices, see, for example, Aulisio et al. 2003; Molewijk et al. 2008; Kaposy et al. 2016; Grönlund et al. 2016). A similar bioethics turn has not been witnessed in Finland, although within the past few decades, some forms of clinical ethics committees, mostly dealing with healthcare policy, have been established around the major hospital districts in the country. Apart from one internet-based ethics consultation forum that offers retrospective analysis and is available only for physicians (Louhiala et al. 2012), the

---

[1] Original name in Finnish, *Lääkäriliitto*.

[2] Original name in Finnish, *Sairaanhoitajaliitto*. The association has changed its name to *Sairaanhoitajat* after the publication of the ethics guidebook analyzed in this study.

kinds of ethics consultation practices that would engage in a case-by-case analysis have not gained foothold in Finnish health care.

Having become occupied with clinical ethics consultation in my previous study (Saxén 2016), I wanted to take a look at the way ethics is culturally constructed for Finnish professionals by consciously adopting what could be called the "bioethics view" on healthcare ethics. This meant deliberately stepping out of the assumption that ethics should be understood as distinctly profession-based in the healthcare setting. Instead, I started with the assumption that nursing and medicine can be looked at from the perspective of a whole rather than as two distant entities. This view is, thus, informed by bioethics in the sense that it constructs the ethos of healthcare ethics in a way that particularly promotes interprofessional dialogue and cooperation. Yet, I recognize that this view of bioethics is contested, which is most clearly reflected in the case of the widely-disputed practice of clinical ethics consultation. However, as this bioethics perspective is currently not very well established in the Finnish healthcare ethics discourse, it offers a point of departure for the researcher to look at the data from a fresh angle. Looking at the discourses of medicine and nursing from this perspective also raises the question whether the two cultures of understanding professional ethics appear to be culturally in harmony or in potential mismatch.

Professional ethics is a widely abstract concept. Roughly defined, it refers to established standards and guidelines—based on shared ideas of what is good and what is right—which define how professionals should behave and act in their practice. In this study, I explore how the two professional groups in their own subcultures make sense of this vague abstraction in their professional writings, how they make it tangible in a way that allows bringing the abstraction to the concrete, to offer tools for the "real world" where a nurse or a physician makes decisions and takes action. I start with the following questions: What is construed as significant in the texts? What is taken for granted? What is expected from the professionals? What is highlighted and what, in turn, is left to the margins of the text? The aim of this inquiry is to illuminate the points at which the angles of vision differ the most. By this understanding, my goal is to open illuminating perspectives on both professions. I also presume that an interprofessional approach of this kind has the potential to deepen the understanding of the empirical nature of professional ethics in a way that may not be possible by focusing on one profession alone (see, for example, Kangasniemi et al. 2015, p. 1755). Grasping the differences between the two professional cultures may also serve to create social space for conversation in between the two professional traditions. My key assumption is that such open space for interprofessional rather than intraprofessional ethics may be beneficial since, in any case, healthcare work is typically a team effort of physicians and nurses working together rather than separately. For healthcare professionals to understand the fundamental worldviews embedded in nursing and medicine, and the differences between them, may be helpful in understanding and supporting the work of interprofessional teams.

Methods

I use the qualitative method of critical discourse analysis (CDA) to explore the cultural landscapes of nursing ethics and medical ethics in the two professional guidebooks chosen for the analysis. Discourse analysis as research method takes as its premise that social and cultural understandings and beliefs are circulated and shaped by the use of language (Fairclough 1992, 2001). The CDA method is *critical* in the sense that it aims at exposing hidden cultural constructions and tensions (Fairclough 1992, 2001).

The CDA method is theoretically based on social constructionism (Berger and Luckmann 1966; see also Burr 1995). This theoretical tradition of the sociology of knowledge presumes that what passes as "common sense knowledge" is culturally constituted through the use of language. Certain language practices become culturally more naturalized than others, and those practices paint a picture of the social world that people experience as solid and real in everyday life (Phillips and Hardy 2002, p. 2). Viewed from this frame of thought, the social organization of professions can be understood as the result of language use: structures created by a social process in which certain ways of talking and conceptualizing have become culturally hegemonic (see, for example, Saxén 2016, p. 101). Discourse analysis, as a research method, attempts to make the familiar again strange by—through the scrutiny of language—directing attention to what has become to be seen as taken for granted. Making these naturalized constructions visible opens fresh perspectives on the open evaluation of cultural hegemonies (Fairclough 2010; Phillips and Hardy 2002).

Viewing the social reality as constructed in this way also refers to understanding texts and other research data as the product of the active selection of cultural resources: some ideas are included in the text, while some other ideas are omitted (Potter and Wetherell 1987, p. 34). In this way, words are seen as used in an effort to "package perceptions and experiences that give rise to particular versions of events and of reality" (Willig 1999, p. 2). These accounts then paint a certain image, while shutting out possible other ways to portray the same cultural themes. The normalization of certain versions of the world brings power into the focus of CDA, as by legitimizing certain understandings as natural and others as less natural—for example, as less credible, doubted, or "alternative"—discourses naturalize hierarchies between people. This cultural naturalization also makes these power relations opaque and difficult to pin down. CDA aims at making the discursive production of power more visible and transparent by scrutinizing what is taken for granted in cultural and institutional practices (Blommaert and Bulcaen 2000). The analysis of this study explores whether such hierarchies are created in the professional ethics discourses of medical and nursing ethics, and if so, in what ways. However, it should be noted that my aim is not to claim that hierarchy, per se, is a problem; nevertheless, being aware of its nuances may help professionals to be critically reflective of their own assumptions as well as of those of others'. Also, making power and authority visible can open discussion about what kind of hierarchies are actually justifiable and functional, and what in turn, are not.

A significant element of the CDA theory is that it views discourses as structural rather than situational: as reflecting widely circulated systems of knowledge that are closely connected to the structuring of practice in society (Fairclough 1992). In the context of this study, the method presumes that the discourses that make up the professional texts are also played out in "real life" in different ways: they are echoed in the ways the two professions are organized, the ways in which professional identities are formed and negotiated, and in the ideological environment in everyday healthcare ethics discourse from the bedside to the administration. Yet, it should be noted that despite identifying prevailing structures of knowledge and belief, the CDA method does not imply determinism: even though the method claims that certain ways of conceptualizing the world have become more hegemonized than others, discourses are not set in stone, but in the social flux of being constantly renegotiated (Fairclough 1992).

Data

The code of ethics for nurses provided by the Finnish Nurses Association (468 words in length) has been published on the Association's website (see Sairaanhoitajaliitto 1996).[3] It was accepted by the Association's general assembly on September 28, 1996. The ethical code for physicians provided by the Finnish Medical Association (306 words in length) is also found on the Association's website (see Lääkäriliitto 2014).[4] It was last updated and published on December 12, 2014.

The nursing ethics guidebook (184 pages in length) is part of a "year book" series in which a thematic publication appears yearly—nursing ethics being the topic of 2012. The book consists of writings collected by the organization from different scholars and practitioners within the nursing field (33 writers in total). Because of this, the book does not represent a canonical view held by the Association but rather a manifold of perspectives on the topic. In contrast, the medical ethics guidebook (254 pages in length) could be said to present the official view of the professional organization, and the book analyzed is the 7th updated edition of the text. Apart from the seven first chapters on pages 11–37, the chapters do not identify their writers. Instead, the book identifies three editors and the organization's official ethics committee as an editorial board, consisting of 20 people. Additionally, a panel of consulted experts is also identified, listing 61 more names. The book is presented as the cohesive outcome of a process of negotiation.

Analysis

The qualitative analysis process of this study can be divided into four phases. I started with the assumption that some kind of order exists in the data, even though this order may not be evident at first. In the first phase, I carefully read through the texts, with the intention of forming a set of primary premises about what appeared to be in the data. I paid attention to what is said and how: what seems to require

---

[3] https://sairaanhoitajat.fi/jasenpalvelut/ammatillinen-kehittyminen/sairaanhoitajan-eettiset-ohjeet/.

[4] https://www.laakariliitto.fi/edunvalvonta-tyoelama/liiton-ohjeet/eettisen-ohjee/.

explanation and justification, and what is just “there,” taken for granted. This deeper scrutiny was mostly relevant for the analysis of the guidebooks, as the short, statement-like guidelines did not make consideration and nuances visible in a similar way. In the second phase, I read through the data again and started to form interpretative categories, keeping in mind that these categories would have to be specific enough to bring out something concrete and tangible of the data but yet abstract enough to manifest themselves in a variety of topics. The third phase of the analysis was the testing of the identified discourses. I read through the data again and asked whether the discourses actually appear throughout the data, testing how well they connect with the ideas existing in it. In this phase, some categories had to be modified or rejected altogether as well as new categories formed. After this, in the fourth part, I once more read through the books in order to check whether my final analysis still appeared accurate. This kind of iterative reading, with the forming and testing of interpretative categories, is typical for qualitative research (see, for example, Marshall and Rossman 1999, pp. 152–164).

All the texts stress the grand themes of healthcare ethics, which in a nutshell could be listed as respect for the patient, confidentiality, autonomy, beneficence, nonmaleficence and justice. I did not go deeper in this study into exploring these ethical ideals. Instead, I paid attention to the ways in which these statements were made, and what kinds of implications, assumptions and consequences were constructed as emerging out of them for the professionals. What became clear from the very start was that despite claiming similar principles, the texts produced the actualization of ethics in very different ways.

When presenting the analysis, I include some data samples that I have picked out of the texts and translated from Finnish into English. I have chosen some examples of the data to elucidate how the discourse appears in the data, and in this way, to let the reader get “inside” the data in a way that would not be possible without including samples of the data. The selection of these samples is based on my own judgment, as the CDA method does not offer a systematic approach to selecting samples out of the data.

Findings

Reflecting on Professional Codes of Ethics

When reading the codes of ethics for nurses and physicians side by side, the first impression is similarity, which is portrayed by the shared principles as well as the form of the texts as listed statements. However, paying closer attention to the language used in the codes raises interesting differences between them. These differences appear in regard to how the patient is referred to, and the nuances as to portraying the significance and meaning of the professions. I will pay attention here mostly to the differences and not to the similarities.

The medical code of ethics appears to be built around central healthcare principles; namely, (in the following order) beneficence, respect, justice, autonomy, nonmaleficence and confidentiality, entangling the principles with notions of professional honor and trust. Physicians are also guided to advance scientific research. The potential colliding of the various principles or statements are not seen as potentially problematic for the physician, as ways of navigating potentially dilemmatic situations are not integrated into the code. Moreover, none of the principles is given the status of primary principle, even though the statements are listed under numbers which gives an impression of a list of priority.

The *profession* as a theme appears forcefully throughout the medical ethics code, constructing a view that ethics is both about how doctors should treat patients as well as the honor and cohesion of the profession. A claimed position of high authority and respect appears to be written into the code. Honor is also constructed as being demanded to be "upheld": "*By her behavior and action, the physician must uphold the honor and trust assigned to the profession and required by the nature of the work.*" This statement is given significant weight as it appears second in the list, whereas, for example, patients' autonomy comes as the fifth statement.

The social sphere in which work takes place appears to be constructed between colleagues and patients and not very clearly in society. Society appears in the context of "*giving testimonies and making statements (…) based on objective perceptions*" but not, for example, as a matter that relates to educating the public or participating in politics. Interestingly, the physician's field of work is constructed as surprisingly apolitical and acontextual as to the larger societal context in which the physician is situated. The physician appears as a bearer of objective knowledge, practicing in the nexus of the doctor-patient relationship and honorable colleagues.

Unlike the medical ethics code, the nursing code of ethics not only refers to the people nurses care for as patients but also as individuals and human beings. The object of work is defined as reaching further than the individual patient, as the code claims nurses "*serve individuals, families, and communities.*" Nurses are also presented as educators for society: "*She* [the nurse] *gives health related knowledge for the public and advances peoples' abilities to take care of themselves. The nurse collaborates with community services as well as disability and patient associations.*" Collaborating with associations puts politically charged societal influence on the nurse's agenda. Also differing from the medical code, in which individuals' work is constructed as projecting the whole profession, the nurse is claimed to "*personally hold responsibility for her own work.*" Yet, work is simultaneously portrayed as not fragmented to single individuals, but instead, collaboration is highlighted: "*Nurses working in the same care community together have responsibility for the quality of the treatment and the constant advancement of this quality.*" The code therefore constructs a view of both individual responsibility and collegial collaboration. The potential mismatch of these ideals is left undiscussed.

This short reflection on the differences between ethical guidelines only scratches the surface of how the construction of ethics differs depending on the professional viewpoint. In the next sections, I delve deeper into the differences between nursing and medicine in the guidebooks analyzed.

Medical Ethics Guidebook: Universal and Objective

The most central topics taken up in the physicians' ethics guidebook, in a nutshell, are the philosophical and societal foundation of the profession, doctor-patient relationship, the beginning and the end of life, physicians' role in society, preventive health care, the unity and status of the profession, clinical research, and working with vulnerable patient groups, such as dying people, children, mental health patients and people struggling with substance abuse. Sources are typically not referred to, but readings on the given topics are listed after most chapters. I counted that of all of the suggested readings, 52% were journals or books (what could be called research sources) and 48% legislative sources, declarations, guidelines or other such directive sources. I also counted whether the research readings were Finnish or international to find out in what kind of ratio the book draws its conclusions from Finnish and international scientific conversations. I found that 79% of the listed research readings were Finnish and 21% international, English language publications. Most of the Finnish language research readings (85 out of 103 sources) were publications appearing in either one of the two mainstream series of Finnish medical publications, Duodecim (either Duodecim press or Duodecim journal) and the medical journal *Suomen Lääkärilehti*.

Discourse of Universal Ethics: Guidelines Carved in Stone

As my task was to look for what was taken for granted in the two guidebooks, one thing that stood out was that the Physician's Oath, written on the first page of the physicians' guidebook, clearly represented the most crystalized form of a concept that holds self-evidence. It is represented as self-standing and extrapolitical, assuming that the concept and its contents are unproblematic and self-explanatory. In addition to the modern Physician's Oath being central to the text, the Hippocratic Oath is also referred to as an eternal entity. This eternality is constructed as unquestionably prestigious and self-evident. The claim that the oath is eternal is also used as a rhetorical tool for legitimizing moral positions: this legitimization frames "not-as-eternal" arguments as less convincing. Yet, it is not openly discussed why the Hippocratic Oath holds such moral authority in defining ethical principles for today's society.

> The physician's commitment to value human dignity and to alleviate suffering does not lead to the claim that a physician would have a duty to help people to die. Even the original Hippocratic Oath separated the medical profession from those whose purpose may have been to end human life with medical procedures (p. 159).
>
> Already in the Hippocratic Oath, the confidentiality of patient records is brought up and this is also a part of the modern Physician's Oath. Patients' trust in their physicians is centrally based on the trust that only the physician will know what has been discussed (p. 56).

> Collegiality supports both the physicians' profession as well as clinical autonomy. It contains as its fundamental part the inner control of the profession, and its self-regulation. Collegiality has been appreciated since antiquity, and in the original Hippocratic Oath, colleagues are seen as parallel to family members (p. 197).

The Oath and the everyday medical practice are produced in the text as a single unity without inner tensions. This construction becomes visible by paying attention to what is missing: cases in which the Oath is ambiguous and other difficult situations, such as those in which doctors may find themselves in conflicts of interest, are not presented as causes of worry. Leaving out the possible tensions within the Oath and the circumstances in which it may be difficult to follow its ethical ideals, the Oath is represented as straightforwardly in tune with practice. In other words, the Oath is not treated as reflecting the basis of the profession in the abstract, but instead as an assurance that the Oath and the physician are inherently one: the idea that the Oath is directly linked to what the doctor does. Thus, the underlying assumption is that a person who has become a physician, has knowledge in medicine, and who has taken the Oath, will also naturally be virtuous in her practice. This virtue is presented as being acquired by setting oneself on a historical continuum of virtuous practitioners all the way from the Hippocratic era to the modern day.

Through the discursive production of the Oath as a self-standing entity, the core of medical ethics becomes presented as universalized and stable. This kind of discourse produces an order in which medical ethics cannot be discussed or evaluated: it just "is." In this way, the construction of the Oath as universal and practical also effaces the possibility that difference of opinion may exist between different physicians, or in society at large. By creating a picture of unity and stability, the potentiality of diverse views as well as of contextual factors are silently given the status of insignificance as a topic to be openly discussed.

Discourse of Biological and Legalistic Reductionism

> The starting or limiting of intensive care must always be based on objective criteria. If intensive care does not hold evaluated benefit for the patient, or death is obvious despite care, care must be abstained or discontinued. In unclear cases, a fixed-period trial of care may be performed. Decisions should be made in agreement with the physician treating the patient's underlying disease. Family must be kept informed. The careful and justifiable documentation of central care decisions is imperative (p. 121, and the entire chapter on making care decisions for ICU patients).

In this data sample, withholding and withdrawing life-sustaining treatment are discursively produced as decisions based on "objective criteria." This objectivity presents these decisions as value neutral. If, on the other hand, a case is unclear—uncertainty may exist—this can be managed by a "fixed-period trial of care," which as a concept also appears to be clear to define. As a consequence, the physician appears as a subject with such criteria available that make ICU patients' end-of-life decisions value neutral; yet, the reader is not told what these criteria are and how they become "justifiable" in the documentation following the decision. Within this discourse, it appears as if there is no mystery in life and death, no critical aspects to ethics and morality, but instead pure facts of which the physician is in possession.

In addition to this biological reductionism, what I have identified as legalistic reductionism is the use of legislation as a source and justifier of ethical conduct. In this discourse, ethics emerges from legislation, and is taken for granted. This kind of discursive frame is used when an ethical standard is represented as flowing out of legislative norms, and not represented as a value concept, a construction that holds many (social, cultural, political, and historical) dimensions: as an idea to be scrutinized, problematized, objected and defended. This leads to legalistic reductionism, the discursive representation of ethics as a rigid system of definitions, detached from the social continuum of morals and politics. In the following data sample, the principle of autonomy, and its exceptions, are framed as appearing out of legal discourse.

> The patient's right to make decisions for herself is documented in the law and international treaties. A physician's duty is to respect the patient's autonomy. The principle of autonomy has exceptions in the legislation, which aim at the patient's right to treatment in cases in which she cannot decide for herself (law of mental health, law of alcohol and substance abuse counseling services, or law of developmental disability) or when a significant societal benefit surpasses individual autonomy (law of infectious disease, and law of mental health). Because exceptions to autonomy are notable events, the significance of policy and documentation is highlighted (p. 43).

Legalistic reductionism frames ethics as a legal question, and presents ethics as a dimension of care that can be handled and solved by careful following of laws and regulations. Between the lines, this legalistic spirit also invisibly transfers moral authority to the law, which may interestingly be partly in tension with the discourse of universal ethics which instead holds the Physician's Oath, in itself, as an authority for moral justification. This elucidates how the discourses are ideologically multidimensional in nature, and how one discourse cannot grasp the cultural content of the data very comprehensively. However, what both of the discourses do, is that they situate ethics discussion at a level that appears to escape open confrontation. Both of the discourses then appear to participate in the construction of medical ethics as authoritative in nature.

Discourse of Non-subjectivity: Psychological Absorption, Controlled Interaction, and Collegiality

> The physician has a duty to use her knowledge and skill for others' benefit always and everywhere when circumstances so demand. The question "is there a doctor present" cannot be bypassed by claiming one is participating only as a private person. Becoming a physician is not limited to studying to become a physician, but in depth, becoming a physician is living one's life as a physician (p. 23).

What I call the discourse of non-subjectivity is already reflected in the discourses represented above in the ways moral decision making is represented as noncontroversial and non-subjective, either in universal or reductionist terms. Nevertheless, I have separated a discourse of non-subjectivity from these two other discourses to emphasize the fading of physicians' subjectivity in the guidebook. Physicians are constructed as physicians rather than subjects, being able to control their feelings and other expressions of subjectivity in their interactions with patients and colleagues. This presentation paints a picture of a physician who can and will control her personality and channel this personality into her practice.

> A good physician is able to utilize the different aspects of her personality and learns to avoid procedures in which her deficiencies complicate conduct and the achieving of objectives. In doing so, the physician does not only utilize her resources of knowledge and skill but also utilizes her own emotional reserves and social skills (p. 23).

The construction of physicians' emotions as something that can be utilized into professional practice creates an assumption that deep psychological absorption is required in becoming a doctor. Yet, limits are proposed to this psychological investment as physicians are guided not to identify with their patients.

> The physician cannot identify with the patient and carry the patient's emotional load, otherwise she will burn out quickly. An exhausted physician cannot treat anybody (pp. 23–24).

The discourse of non-subjectivity creates a social frame in which the personal becomes deeply entangled with the professional, but with exceptions to how much of the physician's inner lifeworld can be merged into her profession. The emotions of the physician are not represented as inevitable, but as controllable. Therefore, a claim that the physician can both be emotionally merged with her work and still avoid identifying with her patients is constructed without inner tensions.

Interaction between physicians and patients is a central topic taken up in the guidebook. This interaction is also presented as being in the doctor's hands, as a controllable encounter. The patient is presented as a feeling subject that may potentially be unpredictable. The physician, on the other hand, is presented as neutral, as if being able to distance her personality from the situation and viewing it from above. The possibility that the physician's personality may influence the encounter is acknowledged but guided to be avoided. These representations thus construct an image of the physician as non-subjective and in control of the social interaction.

> The encounter between the doctor and the patient is asymmetrical in terms of medical knowledge, but on the other hand, it is an encounter between two equal people. The physician must understand both levels of the encounter and take care of the balancing of these levels (p. 46).

> The patient reacts to the doctor's behavior and personality. Shaking hands, saying hello and making eye contact are normal good conduct and help the reception to begin. Notably deviant dressing or behavior on the doctor's part

> may confuse the patient, so bringing out one's own personality very forcefully does not do service to the nature of the work (p. 46).

> At each medical consultation, two personalities and two realities meet: the patient's subjective lifeworld and her own assessment of the explanations of her symptoms, and the physician's scientific judgment (p. 16).

The discourse of non-subjectivity is also reflected in the emphasizing of a united profession. In the stressing of the profession, individuals fade into the background. The idea of a united profession also leaves inner tensions between colleagues mostly invisible, and when potential for tension is mentioned, the sources of tension are framed as unnecessary or able to be easily overcome. The potential disagreement and confrontation between individual physicians that may put cohesion into question is therefore framed as unnecessary, as cohesion in itself is presented as more legitimate and desirable than argumentation. The potential absence of this consensus is also framed as negative without identifying and legitimating the sources of possible tensions. What is left invisible is the possibility that differences in opinion, and open discussion of these differences, may also be fruitful rather than detrimental.

> The principle of collegiality has a strong, practical basis in the profession of medicine. The subjective lifeworld of a physician is limited, and ever since antiquity, it has been important that one can learn from others' experiences. This consideration has continuously been highlighted as physicians have started to specialize more and more. Subspecialties are ever narrower and the treatment of one patient may require the collaboration of several physicians. In these circumstances it is important that collaboration happens seamlessly and in good relations. Disagreement among physicians evokes insecurity in the patient and does not uphold respect for the medical profession in society (p. 197).

In this data sample, disagreement between physicians is represented as in contradiction with upholding a respectful professional status. This clearly differs from the basic presumption of science in which continuous struggle and argumentation are seen to take science and credibility forward rather than backward. Also, the sample brings up an admonition for each physician not to engage in such social action that may "evoke insecurity in the patient." Patients are thereby portrayed as not being able to take insecurity of medical knowledge into account in making their judgments. At the same time, the physician's status is not something to be *achieved* by carrying out good work, but instead something to be consciously and strategically *upheld* by doing certain things, such as not engaging in disagreement. In other words, status is being constructed more as controlled than received. This upholding of professional status is also central to what I have identified as the discourse of threat.

Discourse of Threat: Entangling Trust with Professional Autonomy

> Professionalism requires constant maintenance and promotion on the part of all colleagues. Even though the professional organization has serviced society for millennia, the profession is threatened by many current changes. These are, for instance, the replacement of independent professional practices with employment relationships, the enlargement of the medical profession and subspecialization, the increase of juridical and other outside regulation, and changes in attitudes toward emphasizing individuality (p. 191).

The discourse of threat constructs medicine as a profession under threat. The above data sample shows this threat to be perceived as flowing from many different directions at once. At the same time, a claim is made for the protection of medicine from these various sources of threat, as professionalism is claimed to require "constant maintenance and promotion."

For an outsider to medicine, it appears peculiar that medicine should define itself as a discipline under threat, as it seems reasonable to think that medicine could be seen as by far as one of the most successful and powerful disciplines in modern society. Yet, a discursive positioning of threat creates an image of a vulnerable professional group that must actively engage in the protection of its true authenticity, which is portrayed to be qualitatively something different than the medicine we know today, entangled with many societal and scientific processes, such as regulations and vast subspecialization. By the discursive construction of threat, a silent positioning of resistance to adapting to current cultural fluctuations, such as the expanding influence of individualistic ideology, is also made.

Moreover, the discourse of medicine under threat as well as and the protection against this perceived threat are entangled with the protection of *trust* in the text. In this rhetoric, professional autonomy is presented as the source of trust that flows from society to physicians. Regulation and outside societal interest in medicine are framed as concerned with harboring the best of medicine but failing in the efforts to achieve good results, as these efforts are constructed as leading to the corrosion of trust. Thus, the claim built around trust is that society should not attempt to intervene with the medical profession even if these interventions are aimed at making medicine work better for society.

> The more forcefully decision makers want to ensure all the possible good the profession can produce, the less the profession is allowed independence, elbow room and decision-making power. At the same time, however, the structures that maintain and enhance trust are crumbled. When trust becomes weakened, even positive goals do not lead to successful action, but instead the end result is unsatisfactory or bad for everyone. This is why physicians' ethics and legislation should never conflict with each other (p. 13).

The above data sample builds an argument in which sustaining trust is entangled with the autonomy of the medical profession. Thus, the claim is made that everybody who is concerned about harboring trust between doctors and patients should make sure that physicians have "independence, elbow room and decision-making power." Yet, this does not pay attention to why the trust might be lost by outside intervention. Instead, the trust and its origins appear to be mystical: they are just "there" but not confronted, explored, and explained. Also, concerns for risks that follow from putting people into powerful professional positions are rendered invisible by putting weight only on the benefits that professional autonomy may hold for society.

The argumentation for professional autonomy is not straightforward in the text, as it also anticipates counterarguments. Yet, what happens in the text when the argument is made that medicine cannot be limited only to the inside of the profession is that the topic is turned very quickly back to professional autonomy. This reflects a tendency that could be called a "false beginning:" a claim is made for its rhetorical function, but right after this the topic is changed, which leaves the primary claim in the margin of the text, without real space for justifications or problematizations. Interestingly, though, the false beginning brings out a fragment in the main discourse, hinting that claims built around this viewpoint of professional insularism are under critique.

> The fast development of medical science and the following gap between potential treatments and resources has led to the growing interest of society to supervise the work of physicians. As a consequence, physicians' ethics is more and more part of broader societal discussion and cannot be limited only to the inside of the profession [A false beginning here]. Medicine, medical ethics, collegiality, and professional autonomy are forming a solid web which creates prerequisites for physicians' work, confidential patient-doctor relationship and the fair organization of healthcare services in society. In finding the balance, the cohesion of the medical profession is highlighted for physicians, as well as for patients and society at large. Medical ethics is one of the important links that create cohesion within the profession (p. 12).

Continuing in the theme of outside influence over the practice of medicine in society, the following sample goes on to frame this societal interest as "extreme remedies," which positions the profession as the true source of ethical understanding and discussion. This framing puts more weight on the claim that outside influence cannot be seen as touching upon something that would truly be at the heart of ethical medicine, but only as something extra. As a consequence, a sense of a shared mission between physicians and the rest of society is missing from the narrative, and an understanding of two unities, rather than one, is constructed.

> The inner good of a profession cannot be fostered from outside the profession. Surveillance and sanctions are needed as extreme remedies, but sustainable and ethically high-level practices cannot be created by them. Only a profession that appreciates, fosters, and enhances its main values and conducts its practices in tune with these values can set sustainable goals and foster the moral autonomy of the profession. Medical ethics is not only action for the patient's good, it is also an important factor in strengthening the professional prerequisites for operation in society (p. 13).

The analysis of these citations brings out the observation that professional ethics discourse builds a position in which societal influence is acknowledged but yet silently resisted by leaving the benefits of this societal interest undiscussed. This positioning builds and enhances the idea that medicine must protect itself. As a consequence, a discursive wall is built between the profession of medicine and the rest of society, with an assumption that physicians and society stand on different grounds rather than share a mutual mission.

To summarize, a fundamental foundation throughout the guidebook that appeared to shape the understanding of being an ethical professional was constructed around a claim of objective expertise, based on *knowing medicine* and *being a physician*. *Knowing medicine* indicates an awareness of facts and cures, a knowledge base that is repetitively reminded to be kept updated. *Being a physician* refers to skill in patient interaction and the role of a consultative expert. Additionally, *strong group membership* of a united profession was found to be constructed and highlighted throughout the text. Thus, the physician becomes presented as a neutral expert making knowledge- and skill-based decisions, and rarely presented as a person in the text—as an individual with subjective values and understandings. As a consequence of this neutrality rhetoric, the context in which the values are implemented and the physician's subjectivity become largely, even though not totally, invisible in the text.

It is important to recognize that the identified discourses may have practical consequences. For example, by framing collegial unity as a sign of virtuous and ethical practice and confrontations as unnecessary, it is reasonable to speculate that the discourse of non-subjectivity may make it difficult for individual physicians to express great differences in opinion. In addition, as the discourse of threat positions outside interest in medicine as leading to the crumbling of people's trust in medicine, it may also be hard for outsiders to medicine to have influence in the medical establishment, being perceived as a threat rather than an ally. The discourse of threat also points to the cultural construction of a tight ingroup alliance of physicians, creating an invisible border between physicians and the rest of society that may be difficult to cross. The overall picture is that dissent and confrontation regarding medical ethics are silently resisted and controlled by these diverse discursive practices.

It should also be noted that while the physicians' ethics guidebook appeared to build its claims around certain discourses, it also contained many statements that challenged these discourses or at least represented the physician from a different angle. Despite identifying a deep undertone echoing a construction of universality and objectivity, I also found some discussion about a more humanistic side of medicine, on topics such as empathy. For example, the physician was presented as "*both a detached expert as well as an empathetic, understanding human being*" (p. 15). I first interpreted this production of both expertise and empathy as parallel discourses. Yet, looking at the larger picture, I found empathy to be constructed only on a very general level, as a permanent attitude rather than as a serious realm of work that would require professional and practical guidance. I also found it curious that although empathy is mentioned and highlighted especially in the beginning of the book, the above-mentioned physicians' detachment is presented without tensions, and not presented as a potential challenge or mismatch for empathy, in contrast to what has been suggested by others (see for example Halpern 2001). After closer scrutiny, I started to see the topic of empathy appearing more as a "key word" than a thorough discourse as the other identified discourses—more as a tool for creating and sustaining a positive presentation of physicians than as the construction of a discursive landscape. It could be speculated whether such key words play a role in supporting the hegemonic discourses by making open criticism difficult. As seemingly "everything is covered" in the text, it is harder to point out what kinds of understandings are represented as the true deep undertones that shape cultural thinking and practice, and what is "just talk" in the service of the anticipation of criticism. Such disclaimers may also have strategical relevance in controlling potential opposition and resistance. Anticipating and controlling criticism by disclaimers would be parallel to van Dyjk's (1992) study that found disclaimers expressing tolerant attitudes to legitimize racist discourse in the media.

Nursing Ethics Guidebook: Contextual and Personal

The key topics taken up in the nursing ethics guidebook can be listed as the ethical competence of the nurse, organizational values, leadership, ethical guidelines in care, ethical distress, identifying ethical issues, patients' uniqueness and equality, patient records, identifying and dealing with patients experiencing domestic violence, good death, intercultural interaction, patients' duties, and health care for undocumented patients. In tune with standard academic writing, references are made in the body text to sources listed after each chapter. I counted that 75% of all references were research sources (books and journals) and 25% legislative or other directive sources. Of the research sources, 57% were international, English language publications (123 out of 214 research sources) and 43 (91 out of 214) % of the publications were Finnish.

Discourse of Local of Ethics: Individual, Group, and Society

> Shared values are the basis of discussion about organizational values. One should aim at making oneself aware of them and to discuss their validity (p. 45).
>
> The starting point is that the ethical work environment can be influenced (p. 65).

What I call the discourse of localization of ethics points to a rhetoric in which ethics is seen as part of culture: something that happens, something that can be discussed, and something that can be influenced and changed. Ethics is placed on a social and contextual continuum, and the nurse is represented as being able to make herself aware of these contexts. In this discourse, ethics is constructed as contextual, modifiable and constantly alive—in other words, not stable or universal. Also the assumption is that the nurse is not already aware of these ethical contexts, but instead, can *become* aware of them.

Throughout the nursing ethics guidebook, ethics is produced as local and contextual in this way. The contextuality of ethics is placed within the nurse herself, her immediate work environment, as well as society at large; the locality of ethics appears simultaneously on many levels of social action. The underlying assumption is that ethics is produced in behavior and culture, and thereby ethics is not extrapolitical in nature or isolable from the helter-skelter of the everyday endeavors of being a nurse.

A central element of constructing ethics as tightly connected with local events and subjects is the idea that *change* is possible, as ethics is viewed as bound to people and contexts, not carved in stone. The concept of change brings an alternative reality into vision: something may happen that does not yet exist. In the guidebook, this change is constructed as a form of positive energy, the possibility to go forward. The idea that ethics has potential to change for the better also contains a hidden seed of discontent toward how things are now.

> A lot of experienced nurses and tacit knowledge are leaving organizations. On the other hand, a new workforce entails the possibility of change (p. 65).

Discourse of Enlightenment

> In nursing education, the teaching of ethical guidelines aims at steering future professionals toward the basic values of their professional community. Ethical know-how is one of the goals of learning in [nursing] education, and ethical guidelines can be used for evaluating learning in both theoretical teaching and clinical training. According to research, ethical guidelines are taught in nursing education, but the mastery of these guidelines as well as ethical competence in general are very scarcely studied (p. 59).

What I call the discourse of enlightenment produces professional ethics as a rational endeavor: something that can and should be taught, researched, and developed. Scientific research about issues in ethics is represented as a significant authoritative source that provides knowledge about the world.

The enlightenment discourse places rationality at its center, and from this rational core, it is assumed that the actualization of ethics can be observed and evaluated. This idea of observing ethical practices frames ethics as an ideal and the ethics of everyday practice as two different dimensions that may or may not be in tune with each other. Rationality can be used as a method of observing whether the ethical ideals and everyday life actually meet in nurses' work environments. This rationality presupposes some kind of distancing of oneself from the contexts and social frames that have become common in everyday work as a nurse. The rationality also seems to flirt with both universal and local understandings of professional ethics: the idea that something can be observed locally at the same time assumes that these rational findings are, after all, yet *above* everyday life, setting normative expectations for the local world. The idea of enlightenment follows here the classic enlightenment narrative: rationality gives *light* to something that would exist in darkness without it. It is constructed as a force that may, indeed, guide action; however, this is presented as happening only if people detach themselves from everyday life and set themselves to observe it rationally rather than subjectively.

The underlying idea of the discourse of enlightenment is that such practices and routines may be in place that, when subjected to rational inquiry, appear as ethically questionable. Also, the discourse constructs nurses as people who may act unethically without realizing it: the presumption is that everybody is subject to blind spots that may be exposed by rational thought. Furthermore, work communities and even societies are seen as objects of similar scrutiny. For example, in the following sample, the ethicality of the attending physicians' rounds is questioned.

> Physicians' attending rounds are mostly organized in a way that a doctor, together with a nurse, circles around patients' rooms from one patient to another. The practice can be seen as problematic from the perspective of the privacy of patient records. In the small patient rooms, everybody can hear the discussion going on, which makes the attending rounds public, since patients' information is overheard by outsiders (p. 123).

In keeping with the enlightenment discourse, the demand of rationality encompasses many levels of ethics as a concept. For example, ethical guidelines themselves are also subjected to critique.

> Nurses from different European countries experienced the barriers of utilizing ethical guidelines to be following: 1) the ethical guidelines themselves, 2) nurses, 3) interprofessional team work, and 4) the patient's family networks. Ethical guidelines themselves were experienced as a barrier because they are, by structure, complicated, too general, internally contradictory, or too idealistic (p. 58).

Flowing out of the discourse of enlightenment, national and international research results are a major source of argumentation and justification in the nursing ethics text. Referring to research is a common feature of academic writing, but not necessarily inherent for such a text in professional ethics. For example, the physicians' ethics guidebook that I analyzed does not directly refer to research as legitimation of its arguments, in contrast to the nursing ethics text, even though journals and books are listed as readings. Moreover, the nursing ethics guidebook refers much more to national and especially international research in comparison to the medical ethics guidebook.

By referring to academic research, the nursing ethics guidebook justifies arguments by using a large scale of knowledge accumulated by scientific effort, whereas the physician's guidebook typically utilizes more intraprofessional sources of legitimation, such as the rhetoric of the professional tradition, professional cohesion, and consensus. Also, by not referring to the listed readings, the medical ethics guidebook does not utilize research as an argumentative justification, but only suggests further readings for those who may be interested. This difference could be interpreted to reflect power asymmetry between the two fields: medicine, in itself, appears to be constructed as more "credible" to build and justify a moral argument based on its own professional position and tradition, whereas nursing appears to go through a strenuous effort in referring to research in its aim to convince readers.

Discourse of Moral Agency: Action, Awareness, and Courage

> Meta-skills represent the methods a learner chooses for her own learning and solutions considering her own actions. Such are the observation of one's own actions, making choices in problematic situations, understanding one's own and others' actions, and the control and regulation of one's own actions (p. 32).

I have differentiated a discourse of moral agency from the discourses above, even though it comes close to both the localization of ethics as well as the enlightenment discourse. The reason I have separated this discourse is that the discourse of moral agency creates an "action position" for the nurse, which differs from the discourses above. The other discourses viewed ethics as something that changes and something that one can become aware of. The discourse of moral agency takes these ideas further and proposes that a person may position herself to take action. The discourse of moral agency comes to an even more personal level in this way. The discourse of moral agency also puts significant weight on an individual's moral compass, instead of, for example, social rules or routines. In this way, the discourse of moral agency is deeply rooted in subjectivity: claiming that despite common rules and a shared context, one person can see and interpret things differently. The discourse of moral agency is also emancipatory in the sense that it suggests that people are not victims of circumstances but instead agents of change.

Central elements of this subjective discourse are awareness and courage. These personal virtues are presented as taking the other discourses to a concretely subjective level. Awareness, which also came up in the earlier identified discourses, points at critical evaluation of one's own behavior as well as other people's actions, and the ethical climate in general. Within the moral agency discourse, awareness has a dimension of action: being aware is not a goal in itself but a means of achieving ethical ends. Action, on the other hand, is often presented as requiring moral courage: the possibility of doing something more than is normally expected.

> A new attending physician subscribed the patient to more examinations, ones which the nurse viewed to lead to more suffering for the patient. The nurse questioned the necessity of the examinations to the physician and justified her point of view. After that, the proposed examinations were waived, and the aim instead became to give the patient the possibility to live the rest of her life as well as possible, given the circumstances. The nurse was strong, older, and experienced. She had the courage to discuss her opinion, differing from that of the physician, and to justify her position (p. 74).

Courage represents an especially interesting dimension for discourse analysis as it presumes that something or somebody is standing *against* the person who exercises courage. In the sample above, the underlying assumption is that the physician would not want to hear the nurse's point of view, which yet did not appear to be a problem, since the course of the treatment was changed. The nurse is presented as having power in influencing treatment, but with the assumption that normally a nurse would not do this, since doing it was presumed to require special courage associated with being "strong, older, and experienced." The underlying assumption is that the ethics of treating patients is not on the table for everybody to discuss, but instead physicians define what is right and nurses may either stay silent or, by having courage as an additional force, take their views forward. This underlying tension brings up an intrinsic power imbalance not only considering how treatments are decided, but also as to expressing opinions to influence the process of deciding.

The discourse of moral agency appears to build an empowering position for the nurse against the backdrop of an underlying assumption that a nurse is in a passive role. However, putting weight on individual courage instead of engaging in systemic criticism of the way nurses are positioned may be problematic, as it turns the issue of power imbalance into the personal question of whether the nurse does or does not have the courage to speak out. In this way, it could be argued that accentuating courage may legitimize the power imbalance in a hidden way, as it silences criticism of the way work is organized in the first place. Thus, the discourse empowers nurses as individuals, but it may do it at a price of disempowering nurses as a professional group.

In addition to being active and having courage (what could be called the outward dimension of moral agency), the discourse of moral agency also has an element toward the inward: the close connection of the nurse's personal lifeworld with the role she plays as a professional. The book presents a variety of examples in which a nurse must be tuned to her inner dialogue, an inner guide. This inner dialogue is entangled with the moral agency the nurse is constructed to have. Constructing the nurse's observations and feelings as a meaningful dimension of professional ethics, the nurse's moral agency appears on a continuum "inside and outside": as flowing from the very personal feelings to situations in which the nurse has courage to speak for a patient. Ethics is, thus, framed as something that can be meaningfully experienced. Also, this experience is not presented as controllable in nature, but instead, it is constructed as something inevitable, depending on the circumstances in which a nurse may find herself. Therefore, nurses are not constructed to be in control of their emotions. The following data sample constructs ethics as something that flows out of present circumstances to the nurse's lifeworld, presenting the nurse as experiencing her environment so forcefully that even her mental health may be at stake.

> Ethical stress accumulates when, over a longer period of time, a nurse experiences that she cannot act in the way she sees ethically acceptable. When this anxiety gets worse, it can result in symptoms of burnout and depression. The nurse may experience it as extremely agonizing (p. 69).

To summarize, throughout the nursing ethics guidebook the ethical nurse is constructed as reflective: she takes nothing for granted and is constantly aware of ethics in her everyday work. She is presented as aware of both her environment as well as the depth of herself. The discourses I have identified fundamentally flow out of this idea of reflectivity embedded in the text.

Discussion

This study has identified four discourses in the medical ethics texts—*universal ethics*, *reductionism*, *non-subjectivity*, and *threat*—and three discourses in the nursing ethics texts, namely, *local ethics*, *enlightenment*, and *moral agency*. These findings bring out the observation that while ethical professionalism for physicians is constructed on claims of objective neutrality, universality, and strong group membership, ethical professionalism in nursing is constructed by a reflective approach that highlights nurses' subjectivity. These findings bring attention to how ethical texts construct different kinds of identities and agencies for the professionals. The findings also open a perspective on identifying how significantly different professional discourses and identities can be built around the same ethical principles: namely, respect, confidentiality, autonomy, beneficence, nonmaleficence, and justice.

Through analytical deconstruction of the two texts in professional ethics, attention has been drawn to the fundamental differences between how these professional cultures conceptualize and understand the meanings of ethics for physicians and nurses in the Finnish context. In the analysis, I have also touched upon the question of how power plays into these discursive practices by making visible discourses that may disempower professionals as well as those that aim at negotiating professional status. The political and interest-driven functions of professional ethics is not a new discovery, but empirically these findings can have significance for the understanding of the ideologies and professional cultures and tensions embedded in Finnish health care. These empirical discoveries direct attention to how shared principles may not necessarily be equivalent to fundamentally shared worldviews, and thus, the findings may have potential to challenge the structures and routines of negotiating professional ethics in Finland.

Paying attention to what *is* in the text has, over the course of this study, also led to speculating about what is *not* there. Having identified many differences in the texts, I began to look for signs of conflict and struggle in the texts. As I started to see that the two cultures hold fundamentally different understandings of what it means to be a moral professional, I started to wonder whether these understandings appear to collide with each other in the texts. Are positions openly taken and fiercely defended? To my surprise, I did not find clear signs of open contestation (apart from one case in which the nursing ethics text called an argument typical to the medical ethics text "hypocritical," yet without making a clear reference to the medical ethics tradition). In fact, all the texts appeared to highlight harmony and shared principles. Yet, interestingly, despite expected harmony, the guidebooks did not refer to each other: I did not find reference to nursing ethics from the medical ethics guidebook, and only one reference to the medical ethics guidebook from the nursing ethics one (even though the book I analyzed was published in 2013, an earlier edition of it was out by the time of the publication of the nursing ethics guidebook in 2012). If the two cultures were truly at harmony, would it not be likely that there would be clear and evident intertextuality between the texts and the cultures they represent?

An interesting question for social scientific inquiry, then, is, why do these differences abide and why do they remain, at least seemingly, unchallenged? Very likely such differences and the lack of contestation despite different, competing conceptions, serve important functions in the organization of social action. For example, one could ask whether the construction of expertise and objectivity in medical ethics discourse is, in fact, constructed upon the premise that nursing ethics will not claim such an authority for itself and therefore nursing ethics implicitly and delicately makes space for more powerful and authoritative medical ethics discourse. It is hard to know how exactly these professional ethics discourses eventually intertwine, but arguably, to define both of them as separate and not interconnected to one another is likely to be blind to the relations of power. However, these relations are likely to be very complex and go beyond the realm of this study.

Next, I will address the limitations and potential problems of this study. First, attention should be paid to the nature of the two texts. The nursing ethics guidebook does not present a canonical view similar to the physicians' ethics guidebook. Therefore, one could argue that the books are not commensurate, and thus, should not be brought under such comparative scrutiny. Yet, I was not able to find more commensurate works for the two professions: the cultures and their procedures around constructing views on professional ethics simply are different and thus produce different kinds of texts. So, instead of taking this difference at face value, I found it a fruitful goal to attempt to explain what these differences are like, how do they show, and what are their potential implications for these two professional cultures. This choice is the result of a theory-driven process of constructing an object of research that is methodologically in tune with the theory of CDA (Fairclough 2010, p. 5).

The CDA method is based on theorizing objects of the social world as inevitably interconnected by discourse, assuming that discourse is "not simply an entity we can define independently: we can only arrive at an understanding of it by analyzing sets of relations" (Fairclough 2010, p. 3). Therefore, an analysis of the two traditions of ethics side by side can bring into vision the meaningful differences, relations, and struggles between the two professional cultures that are in any case culturally inescapably bound together by institutionalized health care. While such a transdisciplinary approach may be unconventional for both traditions of nursing and medical ethics, it has potential to open fresh perspectives on and bring attention to nuances that otherwise may escape conscious considerations and scrutiny. The overall aim of this approach is to gain greater knowledge and understanding of the ways in which ethics can take different forms in the ways it is culturally made relevant to the professions. The findings of this study can also raise awareness as to how these differences in the cultural constructions of ethical professionalism are likely also to be institutionalized and naturalized, in some forms, into the systems, structures, processes, and practices of health care in Finland.

Considering the limitations of this study, it is also important to note that while I have picked samples of data to be more closely scrutinized, other content has been given less attention. These choices do not necessarily do justice to the texts, and the cultures they represent, as whole. Also, the discourses I have categorized should not be viewed as absolute and total, but as hegemonic, leaving potential space for other discourses as well. Fragments of the hegemony as well as traces of other discourses are intertwined in the texts, but for analytical clarity, I have identified and categorized only what appeared to me to be the most hegemonic discourses in this study, in order to make the differences between the hegemonies of the two professional cultures visible. In other words, paying close attention to something and making that visible, in turn, typically renders something else invisible, and I am aware of the roughness of the methodological approach of this study.

It should also be noted that the data of this study is naturally very limited in scope, and do not reflect the ways in which ethical understandings appear and are played out in action for either profession—for example, this study does not give answers as to how professionals eventually navigate ethical dilemmas and ethically sensitive situations (about professionals managing ethical role identity, see Cribb 2011). Abbott (1983, p. 857) has stated that professional ethics should be conceptually differentiated from everyday conduct and thus seen as an independent phenomenon, and this detachment of the two dimensions of ethics should be kept in mind when reading this study as well. Moreover, it is important to acknowledge about the data that sometimes texts are somewhat random in nature, depending more on who has written them and when, rather than exposing all the hegemonies of the surrounding culture. More empirical work should be done to find out whether these findings are echoed in the more general professional cultures around the ethics of medicine and nursing, and if they are, in what ways.

However, the analysis does bring attention to some, not all, culturally rooted conceptions of what can be seen as passing as culturally legitimate justifications that shape the ways in which professional ethics are understood in medicine and nursing. Thus, the analysis can offer glimpses of the discourses that have become established and circulated in the ethics talk of the two professions, but by no means maps the whole cultural landscape at once. The results of this study expose a cultural gap between nursing and medicine in the ideological foundations that offer bases for how ethics is culturally understood and negotiated. Therefore, the fact that both professions highlight the same ethical principles, should not be understood as mirroring a more fundamental sense of a shared understanding of what ethics means for health care. The identified potential cultural gap also raises further questions about whether a mutual ground for ethical discussion exists. Yet a question of its own is, of course, whether such shared space for ethical dialogue between professionals is generally seen as a valued goal for Finnish health care or not.

If the claim is accepted that a mutual language of ethics is relevant for interprofessional team work in the healthcare context, it is then clear that the results of this analysis express a need to work toward crossing cultural bridges between the two professions. In other words, social efforts toward bridging the two viewpoints support the general goal of creating conditions for inclusive and interprofessional ethical dialogue in Finland. In defense of this view, it could be claimed that in times of increasing religious and ideological pluralism, advancing medical technology, as well as new treatments becoming ever more expensive and thus unavailable for all who are in need, ethical questions continue to be so pressing that separated professional echo chambers are a cause for alarm. Bioethics, as a discipline (see, for example, Callahan 1973) and as a tool in clinical practice (see, for example, Dubler and Liebman 2011), has not gained prevalence in fostering dialogue in healthcare ethics throughout Finland, but the question remains whether it should. Bioethics as a critical discipline may offer ways to intellectually and analytically separate ethical questions from purely professional ones and to open perspectives on how power shapes the negotiation of ethics in the healthcare field. In my view, it could also be the bridge in the middle that could invite the two worldviews to come together. The kind of ethics that takes as its starting point what is common for professionals rather than what is different may offer constructive ways to work toward finding common ground, toward fostering inclusivity when making value-based decisions. Investing in the development of bioethics discourse, instead of solely profession-based discourses, on healthcare ethics may have the potential to open social space for the kind of dialogue that builds around the very principles that both healthcare professions, despite their differences, already profess to share.

Acknowledgements Thesis supervisors Professor Vilma Hänninen and University Lecturer, Docent Mari Kangasniemi have provided support and guidance in the writing process. Financial support for the writing of this article has been received from the independent, non-profit Emil Aaltonen Foundation.

References

Data Sources

Lääkäriliitto. (2014). *Eettiset ohjeet*. [*Ethical guidelines*.] Updated version. Helsinki: The Finnish Medical Association. https://www.laakariliitto.fi/edunvalvonta-tyoelama/liiton-ohjeet/eettisen-ohjee/.

Ranta, I. (Ed.) (2012). *Sairaanhoitajan eettiset pelisäännöt*. Helsinki: Sairaanhoitajaliitto Fioca. [*Ethical guidelines for nurses*. Helsinki: The Finnish Nurses Association Fioca.]

Saarni, S., Kattelus, M., & Nummi, V. (Eds.) (2013). *Lääkärin etiikka*. Helsinki: Lääkäriliitto and Suomen Hammaslääkäriliitto. [*Physician's ethics*. Helsinki: The Finnish Medical Association and the Finnish Dental Association.]

Sairaanhoitajaliitto. (1996). *Sairaanhoitajien eettiset ohjeet*. [*Ethical guidelines for nurses*.] Helsinki: Sairaanhoitajat. https://sairaanhoitajat.fi/jasenpalvelut/ammatillinen-kehittyminen/sairaanhoitajan-eettiset-ohjeet/.

Literature Sources

Abbott, A. (1983). Professional ethics. *American Journal of Sociology, 88*(5), 855–885.

Aulisio, M. P., Arnold, R. M., & Youngner, S. P. (2003). *Ethics consultation: From theory to practice*. Baltimore: The Johns Hopkins University Press.

Berger, P. L., & Luckmann, T. (1966). *The social construction of reality: A treatise in the sociology of knowledge*. New York: Penguin Books.

Blommaert, J., & Bulcaen, C. (2000). Critical discourse analysis. *The Annual Review of Anthropology, 29*(1), 447–466.

Burr, V. (1995). *Social constructionism*. Abingdon-on-Thames: Routledge.

Callahan, D. (1973). Bioethics as a discipline. *The Hastings Center Studies, 1*(1), 66–73.

Cribb, A. (2011). Integrity at work: Managing routine moral stress in professional roles. *Nursing Philosophy, 12*(2), 119–127.

Dubler, N. N., & Liebman, C. B. (2011). *Bioethics mediation: A guide to shaping shared solutions* (revised and expanded edition). New York: United Hospital Fund.

Fairclough, N. (1992). *Discourse and social change*. Cambridge, UK: Polity Press.

Fairclough, N. (2001). *Language and power* (2nd ed.). Harlow, UK: Longman.

Fairclough, N. (2010). *Critical discourse analysis* (2nd ed.). London: Routledge.

Grönlund, K. F., Dahlqvist, V., Zingmark, K., Sandlund, M., & Söderberg, A. (2016). Managing ethical difficulties in healthcare: Communicating in inter-professional clinical ethics support sessions. *HEC Forum, 28*(4), 321–338.

Halpern, J. (2001). *From detached concern to empathy: Humanizing medical practice*. Oxford: Oxford University Press.

Jonsen, A. (1998). *The birth of bioethics*. Oxford: Oxford University Press.

Kangasniemi, M., Pakkanen, P., & Korhonen, A. (2015). Professional ethics in nursing: An integrative review. *Journal of Advanced Nursing, 71*(8), 1744–1757.

Kaposy, C., Brunger, F., Maddalena, V., & Singleton, R. (2016). Models of ethics consultation used by Canadian ethics consultants: A qualitative study. *HEC Forum, 28*(4), 273–282.

Louhiala, P., Saarni, S., Hietala, K., & Pasternack, A. (2012). Physicians' ethics forum: A web-based ethics consultation service. *Journal of Medical Ethics, 38,* 83–86.

Marshall, C., & Rossman, G. B. (1999). *Designing qualitative research* (3rd ed.). Thousand Oaks, CA: Sage.

Molewijk, A. C., Abma, T., Stolper, M., & Widdershoven, G. (2008). Teaching ethics in the clinic: The theory and practice of moral case deliberation. *Journal of Medical Ethics, 34*(2), 120–124.

Phillips, N., & Hardy, C. (2002). *Discourse analysis: Investigating processes of social construction*. Thousand Oaks, CA: Sage.

Potter, J., & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behaviour*. London: Sage.

Rothman, D. J. (1991). *Strangers at the bedside: A history of how law and bioethics transformed medical decision making*. New York: Basic Books.

Saxén, S. (2016). Untangling uncertainty: A study of the discourses shaping clinical ethics consultation as a professional practice. *Journal of Clinical Ethics, 27*(2), 99–110.

Van Dyjk, T. A. (1992). Discourse and the denial of racism. *Discourse and Society, 3*(1), 87–118.

Willig, C. (1999). Introduction: Making a difference. In C. Willig (Ed.), *Applied discourse analysis: Social and psychological interventions*. Buckingham: Open University Press.

ARTICLE III

Saxén, S. 2018. To Strive Toward Without Reaching: Moral Expertise as a Paradox in Clinical Ethics Consultation. In Watson, J. C. & Guidry-Grimes, L. K. (Eds.) Moral Expertise: New Essays from Theoretical and Clinical Bioethics. Cham: Springer International Publishing.

Chapter 16
To Stretch toward without Reaching: Moral Expertise as a Paradox in Clinical Ethics Consultation

Salla Saxén

> *"The opposite of a correct statement is a false statement. But the opposite of a profound truth may be another profound truth."*
>
> *Niels Bohr*

The debate around the professional status and credibility of clinical ethics consultants has long centered on the problem of moral expertise. In a nutshell, the struggle centers on whether it is possible to identify unique and essential characteristic of moral knowledge that the clinical ethicists possess and other healthcare professionals—or laymen for that matter—do not. How to distinguish clinical ethicists' expertise in moral issues from everyday moral understandings? How to legitimize a professional claim of moral expertise if, at the same time, it is acknowledged that morality refers to subjective values rather than objective knowledge?[1] Consequently, the question of whether, even in a theoretical sense, expertise about values can exist—in other words, moral expertise—has been continuously and heatedly debated for decades. (See for example Noble 1982; Crosthwaite 1995; Shalit 1997; Yoder 1998; Archad 2011; Gordon 2014; Cross 2015; Iltis and Rasmussen 2016.)

In the case of arguing about moral expertise in clinical ethics consultation (CEC), the logic of this debate has typically been the following: If ethics consultants are to claim a professional role in clinical ethics discussions, their position must be grounded on a solid and explicit foundation of expertise in moral issues. Like the cardiologist has undeniable expertise in the functions of the human heart, the ethics consultant should have comparable evidence of her expertise in human morality. Even though it has been argued that this reduction is absurd and the expertise that the ethicist has can never be truly compared to the highly specific expertise in a

---

[1] I acknowledge that the line between values and knowledge is blurred and theoretically more complex than is suggested here.

S. Saxén (✉)
University of Eastern Finland, Kuopio, Finland

J. C. Watson, L. K. Guidry-Grimes (eds.), *Moral Expertise*, Philosophy and Medicine 129, https://doi.org/10.1007/978-3-319-92759-6_16

medical subspecialty,[2] the underlying assumption is nevertheless the same: the ethicist must have at least some kind of recognizable form of moral expertise to validate her position (cf. Priaulx et al. 2016; Yoder 1998). In these debates, the hypothesis has also been that if this legitimation of moral expertise is not reached, the whole CEC practice hangs in the balance. Therefore, the question of moral expertise, with its empirical and theoretical validations, has naturally been very important to the legitimation of CEC as an institutional practice for healthcare.

In this essay, I claim that while the dynamics of arguing "for" and "against" moral expertise in CEC practice is an essential conceptual discussion for academics, it is often a debate that ultimately leads to a paralyzing and insolvable contradiction. At best, it gives credibility and legitimation to the ethicists to do their work; at worst, it jeopardizes efforts to work toward creating open social spaces for value discussions in all kinds of healthcare environments from administration to the bedside. I believe that the debate also indicates an "all-or-nothing" approach that categorically misses the point of why open acknowledgment of values is important in healthcare decision-making, policy and practice. I argue that such an approach also often treats the problem of moral expertise in CEC as taking place in a vacuum that fails to take social dynamics, including power, into account.

As a potential resolution to the problem of the dichotomy, I suggest that moral expertise in CEC practice could be understood as a locus of an inherent paradox. As a baseline for my argument, I maintain that moral expertise can be both defended and rejected with reasonable, rational arguments (as we have witnessed by now). By acknowledging that moral expertise is, inherently and indefinitely, a contestable concept, a third perspective can be envisaged. It is a perspective that takes into account the paradoxical nature of the concept of moral expertise, and strives to understand the politics entangled in and around it. It is also a perspective that attempts to make visible the power that is used around defining moral expertise in professional positions. It does not claim to eliminate power, but it aims to foster the kind of forms of power that are in tune with liberal and pluralistic values. Yet, I will claim that in order for CEC to embrace such a goal, it should categorically resist the overemphasizing of consensus in its professional rhetoric.

The idea of a constitutive paradox and its implications that I use in this essay can be tracked down to political theorist Chantal Mouffe's (2005 & 2013) work, especially to her concept of the "democratic paradox" and the theory of "agonistics." I will not delve into Mouffe's original thought in itself here very thoroughly, but in short, she constructs a model of political order—"agonistics"—that depicts the ineradicability of antagonisms in society. In her theory, Mouffe criticizes the "deliberative democracy" approach (such as Rawls and Habermas) for putting too much weight on consensus, and therefore in her view, intrinsically watering down the recognition that value divisions in pluralistic society are comprehensive and real.

---

[2] For example, Yoder (1998) argues that while a medical specialist embodies *specialist* expertise, expertise can also be *generalist* in its essence. Put simply, while the expertise of the specialist is defined by the depth of her knowledge, the expertise of the generalist is defined by the breadth of her knowledge.

She also claims that the theories that overemphasize the possibility of ultimate consensus categorically miss the most important element of democratic politics, which is seeing the open possibility of dynamic struggle *as a goal in itself*. I will use Mouffe's theory as a baseline and an inspiration in my effort to offer a perspective on the issue of moral expertise in CEC. I will build on the idea that CEC, as well, could embrace the open acknowledgment of dynamic struggle as a goal in itself. I will also connect these theoretical openings to some empirical insights flowing out of my previous qualitative interview study concerning the social construction of professional vision in CEC practice (Saxén 2016). The overall theoretical perspective of this essay can be placed under the umbrella of post-structuralism.

16.1 Mapping the Paradox

Having become familiar with CEC through the general literature and my interview study about the practice, the basic understanding I have accumulated about CEC appears, on a very general level, to point at two central ideas at once. The first idea is the recognition that *value pluralism*[3] is a central principle for healthcare decision-making.[4] The second is the understanding that *expertise* is a key element in fostering decision-making and social order in the conflicted circumstances that inevitably follow from the acknowledgment of pluralism. To build my argument about viewing moral expertise in CEC as a paradox, I start from presuming that these two constitutive constructions, or ideas, together form the basis for the practice of CEC.

The baseline of my argument in this chapter is that while both of these constructions intuitively make sense, they can be seen as being, in a deeper sense, incompatible. While the idea of pluralism acknowledges the lack of an objective perspective on moral matters, the idea of expertise presupposes that a certain version of knowledge serves as a framework to shape moral conversations. The tension between the two ideas is, therefore, profoundly a tension between inclusion and exclusion.

To make a rough simplification of a complex concept, *value pluralism* refers to accepting that everyone has a right to her own moral understanding. This means recognizing the fundamental equality of worldviews and the idea that no one worldview should take dominance over another. What is at stake, then, is the open legitimation of conflict and division in the medical setting (cf. Mouffe 2005, 19). This

---

[3] As Aulisio et al., for example, write in "Ethics Consultation—From Theory to Practice" (2003, 7): "[T]here is no particular privileged substantive moral view. (…) We are religious and nonreligious, utilitarians and Kantians, egoists and natural lawyers, atheists and theists, and we have a right to be so." Overall, I believe this statement to capture the spirit of CEC.

[4] The argument I make is based on a generalization of my empirical findings and what I find to be the ethos of CEC literature. One could ask the more in-depth philosophical question of what version of pluralism is the most productive baseline for healthcare decision-making. In order to focus sharply on my point of introducing a way to view moral expertise as a paradox, I will not address this topic in this essay. Therefore, the absence of a more detailed analysis of the concept of pluralism is a limitation of this text.

acknowledgment of pluralism and conflict also means that a deep foundation of the work of the ethicist is to recognize that diverse value systems have practical implications on medical decisions. For example, in practice, it means acknowledging that conceptions of what constitutes a good death are not based on medical judgments, but value judgments. Clinical ethicists, therefore, bring to the table the open recognition of how medicine and values overlap, and aim at making sense of these connections as well as making them explicit.

Expertise, on the other hand, here refers to a position of knowledge that can offer solutions for working with the pluralism by facilitating value uncertainties and conflicts. The idea of CEC expertise presumes a definitive base of knowledge and skill that the ethicist utilizes in her work. The claim of expertise is also fundamentally based on an act of exclusion: not everybody with moral values can be a moral expert. While the idea of expertise may not suggest moral authority per se, it does imply that something that the expert has learned through her education and experience enables her to bring a more sophisticated view to the negotiation table. The expert can, therefore, be expected to occupy a key position in shaping the direction that the conversation takes.

Consequently, it can be summarized that the ideas of pluralism and expertise seem to have the kind of inner logic that leads to a certain ideological tension—a clash between the inclusion of all views and an exclusion as to who can have the kind of knowledge that shapes and guides the discussion of such views. This inner tension, then, forms the core of what I call the paradox of moral expertise.

It should be noted at this point that my intention is not to trap CEC into a paradox as a form of critique toward CEC practice. Instead, on the contrary, my intention is to introduce the paradox *as a fruitful and productive baseline for CEC*. While I claim that there is a tension between the ideas of pluralism and moral expertise, this does not mean that both ideas were not valuable—that we should not try to embrace them both or that we would have to reject one idea in order to pursue the other. Following the ethos of Mouffe's theory of agonistics,[5] I suggest that it is possible to envisage a tension between two logics in a positive way, as a locus of a paradox rather than as a destructive contradiction.

As the paradox that arises out of the inner tension cannot be solved or closed, it forms an inherent struggle at the heart of CEC that must then be negotiated in and through social and political practices. I will next bring to attention the kind of social dynamics that aim at this negotiating and renegotiating of the relevant spaces for CEC in its professional and institutional communities and working contexts. I suggest that this negotiation appears as a rhetorical play that shapes the goals of CEC differently in different circumstances. I will call this social dynamic the "expertise game."

---

[5] In short, agonistics is a theory that accepts antagonisms and value divisions to be permanent, and presumes that conflict can only be disguised, but not overcome, by social manufacturing of consensus. The theory seeks to show how the existence of this conflict can be channeled in a positive way. "Adversaries fight against each other because they want their interpretation of the principles to become hegemonic, but they do not put into question the legitimacy of their opponent's right to fight for the victory of their position. This confrontation between adversaries is what constitutes the 'agonistic struggle' that is the very condition of a vibrant democracy" (Mouffe 2013, 7).

16.2 Dealing with the Paradox: Rationality, Neutrality, and the Consensus-Rhetoric

When the inherent tensions embedded in the concept of moral expertise in CEC are not openly acknowledged, two typical ways of dealing with the paradox can be roughly identified. The first one attempts to strive toward the perfect rational argument so convincing that it could be thought that the other side of the dichotomy would eventually vanish. As I have argued, this approach becomes eventually impossible, because both sides can be argued for rationally. A convincing rational argument for either side can temporarily eclipse the other pole of the dichotomy, but yet, cannot truly close the debate.

The second way to confront the struggle of the paradox is to deny it—often not straightforwardly, but by implying that eventually CEC does not attempt to legitimize any form of moral expertise after all, but instead only attempts to build consensus, or as I found in my interview study (Saxén 2016), to allow “neutral interaction”. This leads to defining CEC expertise as the ability to create consensus—and not, as one might assume, the ability to argue about, define and understand *ethics* as a system of knowledge. Consequently, the “neutral interaction” rhetoric waters down the whole essence of claiming oneself an *ethicist*, instead of a *mediator*.

Both of these ways of dealing with the inner tensions of CEC start from the underlying assumption that the struggle in itself is insufferable. Therefore, the (invisible and implicit) assumption is that that the paradox must either be hidden from scrutiny or be rationally overcome. Given that the rational arguments are convincing from both sides, I will not go any deeper into exploring the arguments and their implications in this essay. Instead, I will pay attention to the emphasizing of consensus as the goal of clinical ethics consultation. While striving for consensus may be desirable in everyday life for social reasons, I argue that framing CEC fundamentally as a consensus-building effort may be a more dangerous path than is typically recognized. It could be argued that consensus as a primary goal does not do justice to recognizing pluralism and giving the value divisions a channel to be articulated and debated. This is because consensus categorically strives at reframing the inherent value divisions in such a way as to make them invisible. In other words, highlighting consensus constructs divisions in a way that, in a sense, (and put very roughly) makes the differences irrelevant. Therefore, the consensus-rhetoric obliterates the notion of pluralism, as it silences *the struggle* of values that can be argued to be the very condition of pluralism (cf. Mouffe 2005 & 2013).

Furthermore, underlining consensus as a central goal of CEC practice not only raises the question whether ethics is truly synonymous with consensus, but it also presumes that conflicts and antagonisms could eventually be overcome by putting the right professional practices in place. Put differently, it can turn CEC practice into a strategy of controlling divisions and, put in more radical terms, to colonize the moral space by establishing certain procedures through which antagonisms can be limited. Moreover, appealing to ‘rationality’ as a marker of consensus makes power imbalance invisible by assuming that everyone in the negotiation table have similar agencies and abilities to affect the outcome of the deliberation. (Mouffe 2005 & 2013; see also MacIntyre 1988.)

The core of my criticism toward consensus-building is, then, the realization that consensus eventually entails some form of exclusion: not all perspectives can be established in the compromise at once, but the solutions will arise out of a struggle of arguments. The problem I raise is not the struggle in itself, but the consensus-rhetoric that makes it invisible. Such rhetoric also typically abstracts the process of arriving at the consensus as a conversation between equals, which is not necessarily the case. As a consequence of these assumptions, all forms of social and power relations, as well as the subtle workings of deeply rooted cultural traditions and prejudices, tend to be therefore left out of the consensus-rhetoric. Constructing all participants as having equal starting points, therefore, creates an invisible smokescreen that hides the power structures that operate in such deliberations. What I am concerned about is, then, that the consensus-rhetoric "disguises the necessary frontiers and forms of exclusion behind the pretenses of 'neutrality'" (Mouffe 2005, 22). This is because to frame decisions as the outcome of purely rational deliberations is to make space for change and resistance practically impossible, since the "rational" and "pure" consensus silently illegitimates the forms of its challenge (cf. ibid., 32).

It is important at this point to specify that I do not view *power* in this context as an instrument of manipulation or coercion, but instead, as constituting the very identities and agencies that people bring to the negotiation table. Viewing the workings of power in this way arises out of poststructuralist philosophy, essentially Foucault's writings that (defined loosely) present power as something that is being diffused in discourse, knowledge and culturally hegemonic 'regimes of truth'[6] (1995 & 1998; see also Rabinow 1984). In other words, 'truth' or 'knowledge' are not viewed as something that exists outside of people's actions, but instead, truth is seen as "a thing of this world" (Rabinow 1984, 72)—a product of dynamic social action, manifesting through professional roles and expert statements in public discourse such as the media, science and education. In this way, Foucault claims that "power is exercised through the epistemes (underlying order) and discourses found in what passes as knowledge" (Allan 2007, 527). However, it is important to note that for Foucault (among other post-structuralist theorists) power does not appear solely as coercive and exclusive, but also as a productive force that gives shape to a working society. (See ibid.)

Based on this general idea of power as something that constitutes agencies, identities, and knowledge positions, experts in institutional hierarchies can be seen to have power in defining and controlling what counts as sayable and thinkable in the institutional circumstances even if the experts were not aware of this power or mak-

---

[6] "Each society has its regime of truth, its 'general politics' of truth: that is, the types of discourse which it accepts and makes function as true; the mechanisms and instances which enable one to distinguish true and false statements, the means by which each is sanctioned; the techniques and procedures accorded value in the acquisition of truth; the status of those who are charged with saying what counts as true." Foucault in Rabinow 1984, 73.

ing it explicit. Institutional roles therefore shape identity and agendas, reproduce forms of social hierarchy, and create social distance between people (Cribb and Gewirtz 2015, 14). To follow Mouffe (2005, 21), "we should not conceptualize power as an external relation taking place between two pre-constituted identities, but rather as constituting the identities themselves." This is also why power should be understood as something that can never be erased from such institutional environments and transactions.

I believe that while ethics consultants cannot detach themselves from such power-infused institutional processes, it is possible to envision an ideal in which power would be constituted in ways that are compatible with pluralism. This would require the ethics consultant to be aware of the subtle dynamics of who is doing the defining of ethics in different contexts and how, and to make the social process of negotiating the struggle visible. Equipped with analytical understanding of the moral landscape in a complex situation, the ethics consultant can be in a special vantage point to open space for the kind of voices that may otherwise remain silent—but only if the silent voices are not rendered invisible by assuming that they have an equal position in comparison to the more powerful voices in the first place. The ethics consultant has power to make the invisible visible, or the implicit explicit, which was well crystalized in my interview study by an interviewee who told me how she 'goes ahead and states the obvious'— and I quote—"*I will frequently be the person that says you know, maybe I am instigating here, but are you trying to say that you don't respect their beliefs*" (for the data quote, see Saxén 2016, 106). This kind of question is powerful as it challenges the social order of the situation by virtue of making the implicit explicit.

Yet, it should be noted that my criticism of the consensus-rhetoric in CEC does not attempt to make the claim that consensus would not be desirable or extremely relevant for managing difficult and conflictual situations. The ability of the ethicist to work between different worldviews and to find solutions in heated situations is, without a doubt, vitally invaluable and helpful for the everyday hospital life. However, it is important to distinguish this everyday consensus from a more fundamental idea of constructing consensus as professional ideal, and to recognize that building consensus is a secondary goal to the fostering of a vibrant climate of ethical discussions. Yet, it is a difficult task to differentiate between the two: the social demands of consensus-building, and the concept of consensus-building as a professional ideal. My intention here is to focus on the latter, even though the concepts no doubt are overlapping.

I acknowledge that suggesting that consensus building is at the heart of CEC practice in this way is a rough reduction and does not necessarily reveal what the ethicists actually do. I do not attempt to make the statement that ethicists would not see the difference between "consensus" and "ethics." However, I want to pay attention to the neutrality rhetoric and to point out its potential hazards for the goal of openly legitimating pluralism. It should also be noted that in my qualitative interview study of the professional vision in CEC practice, I found that creating consensus through mediation was not constructed as the primary aim of ethics consultation, even though it was mentioned in many contexts. The claim that the ethicist is simply a neutral arbiter (and, implicitly, not an expert in ethics after all), was mostly brought up in the interviews when inherent tensions in the ethicists' role came up implicitly or explicitly. Overall, in my study I found that the clinical ethicists adopt an intricate array of social positions in their hospital work field. Moving between the different expected social roles therefore creates a position of ideological tension for the ethics consultant. (Saxén 2016.)

More specifically, in the analysis of the interviews, I categorized consensus building, or neutral interaction, as a "bridging discourse" that was introduced as an attempt to mitigate inner tensions embedded in the professional vision of CEC. I found a clear tension in the discourses of how ethics consultation is carried through: for example, as to whether a consultation is the outcome of "deliberation" or the expert's "technique" (what I have called the tension between the collective and individual form of agency). However, I did not interpret consensus building to be a fundamental discourse in defining what ethics consultation is about. Discourses that I found to shape the professional vision of CEC were three discourses of order (managerial, emotional, and rational) and agency (exploration, technique, deliberation, and distancing). (See Saxén 2016 for examples and data quotes.) Only in addition to these discourses that I identified as constructing the base of ethics consultation, I interpreted "neutral communication" as a bridging discourse between the above-mentioned, more fundamental discourses, utilized against potential claims that the ethicists' role was illegitimate. These claims did not have to be articulate because I did not make them in my interviews; yet, occasionally during the interviews I found many of my interviewees talking as if viewing me as a potential contestant of their professional claims. I believe this reflected a more thorough social environment that appeared to place the ethicists into a position in which they were constantly shadowboxing against potential resistance. It has stuck with me how one of my interviewees crystallized these tensions well by stating, "*When you are the ethics consultant, you have to be constantly walking on eggshells*."

The management of the inner tensions embedded in CEC practice could be further labelled as the "expertise game" in which the ethics consultant simultaneously adapts a position of expertise in ethics as well as denies this expertise by claiming to be an expert in mediation and conflict resolution, instead of ethics. This observation comes close to what Dzur (2008, 218) calls the "liminality" of ethics consultation, meaning a position "which is neither this nor that, and yet is both" (ibid., original citation from Turner 1964, 7). Such dualistic accounts expose a socially dynamic "game" in which the ethicist is set to a position of fulfilling a range of expectations and must play her part differently in different kinds of situations. It is also important to acknowledge that this game involves other actors as well who have an interest in defining the parameters of ethics in their way. These actors may be hospital administrators and influential physicians, for example. The "expertise game" is, therefore, a dynamic social process in which norms and practices are tested, negotiated and legitimated in a world of social and ideological diversity.

I believe that grasping the nature of the "expertise game," and the tensions in which the ethicist is placed institutionally and socially, can potentially open a perspective on understanding ethics consultation more thoroughly, which helps to make the tensions that CEC practice faces more visible and tangible. It is my aim in this essay to construct a theoretical perspective for understanding the concept of moral expertise in CEC in a way that does not overlook the inner tensions of CEC, as well as the questions of power that surrounds CEC practice, but takes them into account.

16.3 Embracing the Paradox

A central starting point for my argument which has not been articulated very explicitly before is the understanding that the notion of moral expertise is not actually reserved only for clinical ethics consultants. The deeper question is, in my view, ultimately not whether or not the ethicists have moral expertise, but whether ethicists can actually challenge the more institutionalized, hegemonized and subtle forms of moral expertise in the hospital environment in which they work. In other words, even before ethics consultants were there at all, the hospital culture contained often indirect and typically invisible forms of practices that could also be called "moral expertise," such as certain conceptions of right and wrong knit tightly into the physician's profession, as well as the hospital institutions' structures of authority and decision-making (Freidson 1970 & 1988; Rosenberg 1999; Rothman 1991). Yet, these are forms of expertise that rather distort than divulge and clarify the claims of moral expertise. Due to their elusiveness, such forms of expertise are difficult to pin down, as they are typically not explicit, and they have usually been naturalized—put differently, appearing simply "normal"—within the existing conditions, its hierarchies, discourses, and distributions of authority. Especially because such forms of moral expertise are not made explicit, they can offer a strategic position to construct certain versions of ethics without facing open challenge. (For examples of how conceptions of ethics in healthcare professions can implicitly construct social hierarchy, see Saxén 2017.)

The difference between the moral expertise in CEC and the more traditional forms of moral authority in healthcare is therefore not that CEC brings a foundationally new concept of moral expertise into the healthcare organization; rather, CEC merely makes the dispute visible and open for argumentation. This openness may subject CEC practice to constant criticism, but it also contains a seed of wisdom that may be at least partly missing from the more traditional approaches to healthcare ethics. That seed is the *open*, *not implicit*, acknowledgment of values and the ways in which values may conflict in a world that is often exhaustively defined in economic, technological, and narrow professional terms.

Viewing the hospital as an institution shaped by acts of power and struggle creates the backdrop against which I see CEC taking its shape as a social practice that can foster space for pluralistic value discussions. What CEC can bring into open existence in the hospital is the acknowledgment of the *permanence of struggle* without attempting to bring this struggle to a closure. In this way, I view CEC as a practice that can serve to create, in Mouffe's terms, an agonistic space for healthcare decision-making—that is, to provide the hospital institution a social space "where the opponents are not enemies but adversaries among whom exists a conflictual consensus" (Mouffe 2013, xii). Understood this way, conflicts and confrontations are not an obstacle, but instead they indicate that democratic and pluralistic ideals are kept active and alive. This realization of the permanence of the struggle is, to me, what the idea of "keeping moral space open" means in its essence (quoting Walker 1993).

Viewed from this baseline of already existing struggle and negotiation about ethics, CEC appears as an emerging paradigm that challenges the more traditional discourses of healthcare ethics. The potential that I see for CEC is the institutionally embedded agency to create 'fragmentation' in the existing conceptions of 'truth'. Such fragmentation calls debate and vivid argumentation into being. Therefore, I view CEC practice as having potential to articulate the pluralism of values, as well as to challenge the existing hierarchies, in a way that creates open space for diversity. Viewed this way, CEC is seen to be caught in various processes of struggle, and making this struggle openly acknowledged appears as *the point* of CEC practice. Yet, ethics consultants are not above the struggle; they are inside it. Therefore, a real danger is that the ethicist might attempt to establish a position of actually being in control of the struggle, instead of making the struggle open and acknowledged. I view the concept of establishing a fixed sense of 'moral expertise' as a pathway to enabling such a dangerous position. This does not, yet, imply that the ethicist would not have knowledge or expertise in ethics altogether. Simply, it means being reflective and sensitive as to the concept of moral expertise and to the dangers that the concept contains potential to enable an agency of social control.

This perspective offers a way for envisioning the goal of CEC as articulating the existence of value pluralism[7] to all parties in the negotiation table. The goal of such articulation is to make possible to pay attention to various divisions and to create a possibility for *fragmenting the hegemonies*[8] that exist in any given social setting. Yet, to view the goal of CEC in this way is also to recognize that the struggle is never going to be closed. In order to keep the struggle open, in my view, it is crucial to understand moral expertise as a constitutive paradox. According to this view, moral expertise appears as a concept that holds an ideal that can be pursued, but not accomplished or closed. This means stretching toward moral expertise without ever actually reaching it. This is because the position of the moral expert is impossible to reach, since moral expertise is self-contradictory in its very essence—a conceptual impossibility, a paradox (cf. Mouffe 2005, 137). Indeed, to be a moral expert—as

---

[7] Again, a discussion of its own—which is out of the scope of this chapter—is what kind of understanding of pluralism is the most functional and justified to serve as the basis of CEC practice.

[8] A concept close to Foucault's "regimes of truth," hegemony refers to an established idea that has become so normalized in a given cultural setting that it is seldom openly questioned (Gramsci 1971 as cited by Fairclough 1992, 91–96). Many poststructuralist social research traditions, such as critical discourse analysis, presume that hegemonic social constructions that shape and constrain thinking in a given culture can be discovered by studying the use of language. While hegemonies present some culturally embedded ideas as normal, as "common sense," they silently marginalize other ways of thinking. (Ibid.)

understood in the sense of becoming a legitimated moral authority—would be to abolish the concept of recognizing authentic value pluralism, and therefore, to obliterate the whole basis for ethics consultation. Therefore, the expertise in CEC practice can only sustain as long as it is recognized that moral expertise cannot be reached—that is, only in so far as ethics consultants acknowledge the particularity and the limitation of their claims of moral expertise.

Acknowledging the paradox as the baseline of CEC and not attempting to close it may be the best way to foster the kind of profound value conversations CEC claims to enhance because open acknowledgment of the paradox would protect CEC practice against any attempts at establishing a closure of what moral expertise is. To acknowledge the inherent paradox is, therefore, to guarantee that the dynamics of open moral deliberation will be kept alive. This is crucial for recognizing that social space will always be ordered by certain versions of the truth, while leaving other narratives to cultural margins. The forceful recognition of the tendency of communities and institutions to establish certain versions of the truth can offer an open social space, "wiggle room," that is conducive to a broad acknowledgment of pluralism. Against this backdrop, the ethics consultant therefore could be thought of as being in a legitimated position for opening the discussion of pluralistic values and possibilities.

The professional challenge for CEC in my opinion is, thus, not to legitimize the concept of moral expertise, but to construct a claim of expertise strong enough to institute social space for facilitating value discussions, making them visible without actually permanently and fully defining moral expertise. The foundation of this claim is that without conscious efforts at making ethics visible, healthcare communities will develop value-laden and interest-ridden practices that, despite good will, may not necessarily benefit the patients and the public but the definers and the decision-makers. Making ethics visible may not reverse the impact of such influential dispositions, but it does cast light on existing decision-making practices and creates a due diligence process, categorically placing (at least to some extent) the burden of proof on the power holders. Therefore, CEC can construct social space for "a kind of interaction that invites something to happen, something which renders authority more self-conscious and responsibility clearer" (Walker 1993, 33). Yet, it is obviously important to recognize that the corruptive elements of power cut both ways, and that by legitimizing a position of "knowing ethics," ethics consultants themselves may attempt to establish an order that benefits their own professional aspirations.

In my view the deeper question about the legitimation of ethics consultation is, then, fundamentally not about moral expertise at all. It is eventually about the professional identity of clinical ethics consultants and the possibilities that identity entails—to put roughly, the question is whether ethics consultants become agents of manufacturing institutionally approved consensus, or whether ethics consultants are able to open spaces for a more pluralistic range of voices. In order for ethics consultation to open new horizons for the more traditional and profession-centered healthcare ethics ethos, it has to be clear that real alternatives are at stake.

Finally, it is reasonable to ask to what end, if any, these remarks bring us. Many critical writings on CEC are based on explicit or implicit assumptions that doing something differently will make CEC a better practice. While I have claimed that CEC should not fall into overemphasizing consensus, I want to resist the intuitive idea that this utopia would become closer by suggesting concrete changes. Instead, my endeavor has been to show that while the professional claims of CEC hold inner conflicts and tensions, these tensions are not detrimental to the goal of creating open space for moral discussions. I have attempted to argue that ethics consultants are in a special vantage point that has the potential to create awareness that is critical toward the clinical knowledge systems, rules and social hierarchies. All in all, my intention has been to demonstrate that making visible the moral realm of clinical decision-making is *in itself sufficient, because it opens up possibilities*. However, the task set for ethics consultants by these words is unquestionably difficult. How to actually use power in a way that is in tune with pluralism? How to define one's professional identity as someone who is both "knowing" and "not-knowing"? How, in other words, to embody a paradox? The essence of the challenge is well captured in a quote by Pakistani writer Raheel Farooq: "*Intelligence is to spot paradoxes. Wisdom is to live by them.*"

References

Allan, K. 2007. *The social Lens: An invitation to social and sociological theory*. London and New Delhi: Sage Publications.

Archad, D. 2011. Why moral philosophers are not and should not be moral experts. *Bioethics* 25 (3): 119–127.

Aulisio, M.P., R.M. Arnold, and S.J. Youngner. 2003. *Ethics consultation: From theory to practice*. Baltimore: Johns Hopkins University Press.

Cribb, A., and S. Gewirtz. 2015. *Professionalism*. Cambridge, UK: Polity Press.

Cross, B. 2015. Moral philosophy, moral expertise, and the argument from disagreement. *Bioethics* 30 (3): 188–194.

Crosthwaite, J. 1995. Moral expertise: A problem in the professional ethics of professional ethicists. *Bioethics* 9 (4): 362–379.

Dzur, A.W. 2008. *Democratic professionalism: Citizen participation and the reconstruction of professional ethics, identity, and practice*. University Park: Penn State University Press.

Fairclough, N. 1992. *Discourse and social change*. Cambridge UK: Polity Press.

Foucault, M. 1995. *Discipline and punish: The birth of a prison*. London: Penguin.

———. 1998. *The will to knowledge: History of sexuality*. Vol. 1. London: Penguin.

Freidson, E. 1970. *Professional dominance: The social structure of medical care*. New Brunswick: AldineTransaction.

———. 1988. *Profession of medicine: A study of the sociology of applied knowledge*. Chicago: University of Chicago Press.

Gordon, J.S. 2014. Moral philosophers are moral experts! A reply to David Archad. *Bioethics* 28 (4): 203–206.

Gramsci, A. 1971. Selections from the prison notebooks, ed. and Trans. Q. Hoare and G. Nowell Smith. London: Lawrence and Wishart.

Iltis, A.S., and L.M. Rasmussen. 2016. The "ethics" expertise in clinical ethics consultation. *The Journal of Medicine and Philosophy* 41 (4): 363–368.

MacIntyre, A. 1988. *Whose justice? Which rationality?* Notre Dame IN: University of Notre Dame Press.

Mouffe, C. 2005. *The democratic paradox*. London: Verso.

———. 2013. *Agonistics: Thinking the world politically*. London: Verso.

Noble, C.N. 1982. Ethics and experts. *The Hastings Center Report* 12 (3): 7–15.

Priaulx, N., M. Weinel, and A. Wrigley. 2016. Rethinking moral expertise. *Health Care Analysis* 24 (4): 393–406.

Rabinow, P., ed. 1984. *The Foucault reader: An introduction to Foucault's thought*. London: Penguin.

Rosenberg, C.E. 1999. Meanings, policies, and medicine: On the bioethics Enterprise and history. *Daedalus* 128 (4): 27–46.

Rothman, D.J. 1991. *Strangers at the bedside: A history of how law and bioethics transformed medical decision making*. New York: Basic Books.

Saxén, S. 2016. Untangling uncertainty: A study of the discourses shaping clinical ethics consultation as a professional practice. *Journal of Clinical Ethics* 27 (2): 99–110.

———. 2017. Same principles, different worlds: A critical discourse analysis of medical ethics and nursing ethics in Finnish professional texts. *HEC Forum* 30: 31. https://doi.org/10.1007/s10730-017-9329-0.

Shalit, R. 1997. When we were philosopher kings: The rise of the medical ethicist. *New Republic* April 28: 24–28.

Turner, V.W. 1964. *Betwixt and between: The liminal period in rites de passage*. Seattle: American Ethnological Society.

Walker, M.U. 1993. Keeping moral space open: New images of ethics consultation. *The Hastings Center Report* 23 (2): 33–40.

Yoder, S.D. 1998. The nature of ethical expertise. *The Hastings Center Report* 28 (6): 11–19.

SALLA SAXÉN

This thesis examines moral uncertainty in healthcare ethics discourse in three professional realms and two countries: clinical ethics consultation in the U.S. as well as medical ethics and nursing ethics in Finland. The multiprofessional study setting builds on bioethics and its claim of seeing healthcare ethics as a multidisciplinary topic that extends beyond professional boundaries. In the end, keeping moral space open through structures that support interprofessional dialogue is advocated.

UNIVERSITY OF
EASTERN FINLAND

uef.fi

PUBLICATIONS OF
THE UNIVERSITY OF EASTERN FINLAND
Dissertations in Social Sciences and Business Studies

ISBN 978-952-61-3756-8
ISSN 1798-5749