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# Taking a moral holiday? Physicians' practical identities at the margins of professional ethics

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Received 27 June 2022

Accepted 23 September 2022

**ABSTRACT**

Physicians frequently encounter situations in which their professional practice is intermingled with moral affordances stemming from other domains of the physician's lifeworld, such as family and friends, or from general morality pertaining to all humans. This article offers a typology of moral conflicts 'at the margins of professionalism' as well as a new theoretical framework for dealing with them. We start out by arguing that established theories of professional ethics do not offer sufficient guidance in situations where professional ethics overlaps with moral duties of other origins. Therefore, we introduce the moral theory developed by Christine M. Korsgaard, that centres around the concept of practical identity. We show how Korsgaard's account offers a framework for interpreting different types of moral conflicts 'at the margins of professionalism' to provide either orientation for solving the conflict or an explanation for the emotional and moral burden involved in moral dilemmas.

**PROFESSIONAL ETHICS AS A SUBJECT OF MULTIDISCIPLINARY INQUIRY**

Physicians' professional ethics plays a dominant role in contemporary healthcare debates, be it on the use of Artificial Intelligence, end-of-life issues, research ethics, biosecurity or—more recently—pandemic planning.<sup>1 2</sup> The moral dimension of healthcare professionalism builds a theme frequently invoked in academic, educational, political and public spheres. Most notably, professional associations of physicians and other healthcare workers feel addressed when it comes to decision-making about ethically laden questions concerning healthcare issues on the individual, institutional or societal level. Medical associations are the most prominent issuers of written standards of professional ethics, such as the AMA Code of Medical Ethics,<sup>3</sup> the Declaration of Geneva<sup>4</sup> or the Charter on Medical Professionalism.<sup>5</sup>

When one takes a closer look, however, professional ethics appears as a remarkably iridescent term, which is used in practical and theoretical contexts and the subject of a number of disciplines and discourses: Historical studies highlight the transformation and the stability of moral norms pertaining to medical practitioners, which were documented as early as in the Hippocratic Oath originating from the fifth to third century BC.<sup>6</sup> Empirical studies from the sociology of the professions also unveiled myths and ideologies associated with professional practice.<sup>7 8</sup> From this perspective, professionalisation remains an ethically ambivalent phenomenon: potentially contributing to a high quality of services and social welfare, it might also

perpetuate hierarchical structures and privileges of certain groups of healthcare workers. Another major field of discourse has developed more recently in the domain of medical education. In this context, 'professionalism' is often depicted as a set of behaviours that are trained and expected from medical students and doctors as a requirement for qualification and maintaining good medical practice.<sup>9</sup> Understood this way, professionalism does not primarily aim at promoting ethical sensitivity or reasoning skills but rather refers to the adherence to a set of standards or codes of conduct.<sup>10</sup>

Due to the variable use of the term, it needs to be clarified that in the context of this article 'professionalism' is used to generally describe the occupational activities of doctors as a distinct group of skilled workers. According to the sociological literature, professional practice (in contrast to doing a 'mere job') is characterised by certain features such as professional autonomy, academic excellence, institutional self-control and the emergence of ethical standards. The sociologist Eliot Freidson furthermore states that the 'soul of professionalism' finds itself expressed in professional codes of ethics.<sup>11</sup> As professions are dealing with concerns that are of high significance for their clients and contribute to the preservation of important common goods, the commitment to fundamental ethical principles, such as individual and societal welfare, scientific excellence or collegiality, stand in the centre of professional practice. In this article, we, therefore, treat professional ethics as a key trait of doctor's professionalism which has, at first glance, a contingent nature (as it has developed historically) but nevertheless can be meaningfully analysed from the perspective of ethical theory.

Whereas codices of professional ethics have been documented since antiquity, explicit philosophical analyses of this empirically rich phenomenon started only half a century ago. A major focus of the early debates on professional ethics, originating from the 1980s, was on the question whether there is an internal morality of medical practice that functions as a source of moral obligation for physicians. According to Edmund Pellegrino, professional ethics does not rest on a source 'external to medicine'—such as a philosophical theory or a social construction—but emerges from the nature of the clinical encounter as a unique human relationship between patient and physician.<sup>12</sup> This 'essentialist' conception of professional ethics is opposed by Robert Veatch, who holds a morality internal to medicine impossible because of multiple medical roles and conflicting ends and purposes. Veatch argues that 'the ends of any practice such as medicine must come from outside the practice, that is,



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**To cite:** van Gils-Schmidt HJ, Salloch S. *J Med Ethics* Epub ahead of print: [please include Day Month Year]. doi:10.1136/jme-2022-108500

from the basic ends or purposes of human living' (13, p621). Attempts at justifying professional ethics by reference to the clinical encounter have become even further strained recently due to the dissolving boundaries between the clinical sphere and other social realms (eg, Social Media<sup>14</sup>), fuelled by the digital expansion of the healthcare system.

Contractualism provides an alternative, prominent theoretical framework for explaining physicians' ethical commitments and role in society.<sup>15</sup> The social contract notion of professionalism rests on the assumption that rational actors freely chose to make an agreement resulting in reciprocal obligations. Mathew Wynia highlights that such a contractualist model of professionalism mirrors the self-understanding of 18th century US citizens (people as equals, contracts between willing parties) well and, therefore, emerges from a context in which the American Medical Association, as the first modern organisation of professionals, was founded in 1847.<sup>16</sup> The (implicit) contract between physicians and society contains the reliable and high-quality provision of healthcare as a highly important good in return for the assertion of certain privileges, such as good remuneration, monopoly and professional self-determination. The assurance of professional self-control is still documented today in various international legislations that attribute exclusive rights to distinct groups of highly qualified professionals. In a contractualist understanding, professional ethics, thus, arises from reciprocal obligations between members of the profession and society which finally serves the needs of the recipients of healthcare.

Some more recent ethical approaches highlighting that a *supererogatory* component is necessarily inherent in professional ethics are not easily compatible with a contractualist understanding of healthcare professionalism. Kole and De Ruyter, for example, argue that an aspirational dimension of professional morality needs to complement the deontic, 'rule-based' character to account for the fact that good professional workers are pursuing ideals instead of merely following rules.<sup>17</sup> They argue that the individual and collective dimension of professional ethics can be adequately reconciled only by referring to ideals. According to Kole and De Ruyter, 'A reduction of the moral dimension of professional practice to deontic normativity would cut off professionals from vital moral knowledge, motivation and meaning' (13 p135). Relatedly, Jonathan Bolton introduces the notion of 'sur-moralism'<sup>18</sup> to capture physicians' actions that are not based on obligations but are voluntary and potentially meritorious. Such supererogatory actions are based on personal choice and shift the focus from the social ethics of the profession to the individual ethics of the physician.<sup>18</sup>

Against the background of these existing discussions, this article aims at taking a fresh view of the character, scope, and limitations of professional ethics by using concrete challenges occurring in physicians' daily life as starting points. A special focus is set on issues that are situated 'at the margins of professionalism', insofar as they not only affect physicians in their professional role but also relate to other lifeworld domains and ethical standards. Ethical issues situated at the intersection between job activities and other fields of practice have largely escaped the attention of theories of professional ethics, and have only been sporadically addressed so far.<sup>19</sup> Yet, the situations we speak of are frequent and often morally challenging to physicians, while hard to address with the theoretical 'tools' available in medical ethical theory so far. Approaches, for example, referring to the internal morality of medical practice or drawing on a contractualist understanding do not provide sufficient guidance in situations which cannot be unambiguously characterised as being part of a physician's 'job'. Similarly, the reference to

supererogatory components of professional action often falls short in answering the question how far physicians are ethically obliged to go when it comes to situations which do not clearly form part of their professional work but are otherwise related to their competencies and authority as members of the profession. Such overlapping or 'grey' areas of physicians' practice might, therefore, be particularly suitable for demonstrating the specific character of professional ethics and its relationship to other, nonprofessional normative standards.

One example of such a situation at the margins of professionalism recently gained new attention. This example centres around the Goldwater Rule, a policy adopted by the American Psychiatric Association (APA) that forbids its members to express professional opinions – without first-hand evaluation and authorisation by the person—on public figures.<sup>20</sup> This policy has been controversially discussed since the presidency of Donald Trump.<sup>21</sup> The tension that arises here at the margins of professionalism is that between the obligation the psychiatrist has qua being an APA member and the obligation they experience based on, for example, their civil duty to inform the people about potential dangers they perceive.

By offering a taxonomy of situations that occur at the margins of the medical profession, this article accounts for the fact that a physician is not only a physician but also a human being acting in multiple roles that each comes along with distinct demands. The ethical character of such multiple potentially conflicting normative affordances is analysed in referring to Christine Korsgaard's moral theory of practical identities as a theoretical framework, explaining the origin, scope, and limits of the various obligations that we impose on ourselves as humans. The main aim of this article lies in a further clarification of the nature of professional ethics. In particular, a new framework is provided for interpreting ethical challenges to physicians, which occur at the margins of their work settings. The framework contributes to a deeper understanding of how ethical conflicts at the margins of professionalism might be resolved but also to a better grasp of the theoretical and conceptual obstacles that might prevent physicians from finding ethically acceptable solutions at these margins.

### Ethics 'at the margins' of professionalism

Life experience and empirical evidence indicate that physicians often find themselves in situations in which their professional practice is intermingled with other affordances, be it in contact with family and friends,<sup>22</sup> political dynamics<sup>23</sup> or social media.<sup>14 24</sup> Such situations 'at the margins' of physicians' professional practice often remain neglected in the theoretical debates on professional ethics, as displayed above. The following tripartite taxonomy provides an overview of contexts of action which that are closely related (or form part of) the physician's 'job' but are also connected to normative demands emerging from other domains of the physician's lifeworld or from general morality pertaining to all humans.

According to our view, normative demands emerging from the medical profession can go beyond common morality (eg, the kind of aid that professionals must provide to strangers), the profession's demands may stand in direct conflict with common morality (eg, in relation to medical confidentiality and the harm to a third party a patient expresses to intend), or professionalism may conflict with demands coming from other sources than common morality (eg, obligations one has as a medical professional and as a parent). Although more examples at the margins of professionalism certainly can be thought of, we contend that these can be categorised in one of these three types of relations.

### Category 1: professional ethics reaching beyond common morality/'taking a moral holiday'

Situations can occur in which professional ethics appears to be either more demanding or more restrictive than moral norms pertaining to nonprofessionals. Even outside the job context, there are situations in which the requirements for adequate action are higher for individuals who are healthcare professionals compared with mere 'bystanders'. Documented professional duties and legal regulations regarding such cases refer, for example, to vehicle accidents or the sudden cardiac arrest of a stranger.<sup>25</sup> Physicians (and other healthcare staff) are usually required not only to provide assistance but give support in a medically appropriate way due to their medical knowledge and competencies. An ethical duty can be ascribed to physicians to act for the welfare of strangers and people with whom they are in close contact not only in emergency situations but also in accidentally witnessing signs of (chronic) pathological conditions.<sup>26</sup> Conversely, there are situations in which physicians' scope of action is more restricted compared with nonphysicians. There are, for example, professional laws banning assistance in suicide, even in countries where such assistance is not forbidden for 'common citizens'.<sup>27</sup> Reasons cited for more restrictive rules for physicians often refer to their status as members of a profession that is highly trusted regarding individuals' and public health.

Yet, it can be discussed whether it is legitimate for physicians to free themselves from moral obligations arising from their professional status at least on some occasions. Are physicians (morally) allowed to go on a 'moral holiday'<sup>28</sup> such that they are relieved from being bound to their specific professional ethics? Apart from emergency situations, it is often legally and ethically unclear in how far physicians are still obliged to provide medical help to nonpatients and what are the conditions of, for example, diagnosing and treating family members and friends. Even after the working time ends, physicians' professional knowledge and competencies remain the same and occasionally could be applied gainfully. On the other hand, there is no doubt that physicians need rest and recovery, similar to any other group of workers.

The most recent revision of the World Medical Association's Declaration of Geneva includes a provision on physicians' self-care by stating that 'I WILL ATTEND TO my own health, well-being, and abilities in order to provide care of the highest standard'.<sup>4</sup> This newly introduced passage might also be interpreted against the background of the question whether physicians may go on 'moral holiday' (or at least on a 'professional ethics holiday') when their working time is over or whether they are still bound to professional standards. Does it lie in the scope of the physician's responsibility for people's health-related welfare after taking off the gown that 'self-care' and their free time should be instrumentalised for their professional aims? Or could that too easily lead to physical and psychological overload and pose a threat to physicians' own health and integrity?

Such questions of moral obligations outside working hours cannot be answered easily when referring to the supererogatory character of professional norms, particularly if we consider that sticking to a very demanding interpretation of professional ethics ('no moral holiday') could easily violate key aspects, such as preserving one's health and the permanent provision of excellent services. Similarly, a contractualist understanding of professional ethics does not give a precise answer to the question whether the (collective) contract of the medical profession with society allows individual members to have any 'moral free time' from professional ethics when they are not at work. Yet, the specific character of physicians' time outside work asks for

further negotiation of the relationship between professional ethics and common duties arising from socially shared norms.

### Category 2: professional ethics conflicting with common morality

Other situations may arise in which—within medical practice itself—duties of professional ethics might conflict with ethical duties arising from common morality as a source of obligation pertinent to everybody. One potential field of moral conflict, for example, relates to medical confidentiality. If a psychiatrist gets to know about the plans of a patient to inflict damage on other people, confidentiality and a trustful therapeutic relationship need to be weighed against saving third parties from harm—people to whom the physician does not have a professional relationship but only a general duty to protect them from harm. If a non-healthcare professional gets to know about the serious and harmful intentions of, for example, a neighbour, a moral requirement would probably be to seek help (eg, by calling the police). A physician, by contrast, is not only bound by a general moral commitment to prevent harm to others but is also in a trustful relationship with the patient who is suffering from a mental illness. This concept of trust transgresses the individual patient–physician relationship and is usually seen as a trust in the entire medical profession, which can be harmed if a member of the profession does not stick to the principle of confidentiality. Trust in the medical profession, again, is a major prerequisite of the healthcare system to function.

Very different conflicting situations may arise if a physician needs to weigh between environmental and sustainability aspects of their practice and the convenient and effective treatment of—especially minor—conditions. The complex interdependencies between the environment (eg, climate change) and public health<sup>29</sup> are gaining increasing attention at the moment together with the impact of healthcare institutions on 'planetary health'.<sup>30</sup> A sustainable transformation of the healthcare system is often seen as a key task for ensuring the provision of reliable medical services in the long run.<sup>31</sup> A global orientation towards future generations and the planet on some occasions, however, might be in conflict with serving the needs of individual patients presently under treatment. According to the Declaration of Geneva and other preeminent documents of professional ethics, a physician is foremostly obliged to serve the healthcare needs of the individual patient of whom they are in charge.<sup>32</sup> If this obligation conflicts with the ethical duty of protecting the environment, there is a tension between professional norms and ethical demands directed to everyone and not only to professionals. As an example, a critical situation might occur if a physician wants to prescribe a dry powder inhaler to a patient for the treatment of their respiratory disease, as this inhaler does not contain greenhouse gasses, but the patient refuses.<sup>33</sup> Here the physician needs to decide between their duty to respect the autonomy of the patient as well as protecting the patient's trust in the treatment and lessening the negative impact on the environment.

### Category 3: professional ethics conflicting with particular moralities of other origins

There are other fields of conflict that refer to weighing moral duties of a physician acting in multiple roles. Physicians, in addition to the job function, usually have other social relationships. Therefore, professional norms might conflict with moral requirements resulting from other roles the physician occupies. If a psychotherapist, for example, uses their professional network to provide a depressive friend with a treatment (in a healthcare system in which there is a notorious underprovision

of psychotherapy), the moral duty to help a friend (and in a severe case, perhaps prevent a suicide) stands against the requirement of a fair and transparent allocation of scarce healthcare resources, which is typically seen as a professional duty of physicians.

Another severe conflict of ethical duties could happen to an intensive care physician who is a parent or taking care of frail older family members in a pandemic. First, as with many other occupations, physicians are under heavy strain with a high workload in a pandemic due to the high occurrence of critically ill patients and potentially also by taking over the working shifts of colleagues who are sick, in isolation or quarantine. In addition, they need to carry the risk of spreading the infection from their work place to their loved ones. Trade-offs then need to be made between familial duties (eg, childcare or preventing susceptible family members from infection) and taking extra shifts on the ward.

Such cases of conflict between professional ethics and particular moral duties of other origins cannot be adequately solved by reference to the internal morality of medical practice or a contract between the medical profession and society. These cases just take place at the margins, where the boundaries of professionalism become fuzzy due to obligations that stem from different sources. An ethical analysis of these cases needs to account for the fact that members of the medical profession are simultaneously deeply embedded in other social contexts, which heap further responsibilities on them.

#### KORSGAARD'S MORAL THEORY: PRACTICAL IDENTITIES AS SOURCES OF OBLIGATIONS

We propose that the multiple normative affordances that are embedded in situations with which medical professionals are confronted at the margins of their profession can be elucidated by Christine Korsgaard's moral theory of practical identities.

Korsgaard's moral theory of practical identities is grounded in the affirmation of our autonomy and the image of ourselves as reflective and voluntaristic beings who act on the rationality of reasons. According to Korsgaard, reasons spring from the reflective structure of our mind, as we no longer act automatically on impulses due to a distance between our reflective capacities and our impulses. We are, therefore, in need of reasons to endorse or deny our impulses, which now appear as inclinations, as a ground on which to act. However, the reflective structure of our mind also creates the possibility to ground the endorsement or denial of the inclinations as it forces 'us to have a *conception* of ourselves' (34, p100).

Korsgaard calls this conception our practical identity. Practical identities provide 'a description under which you value yourself, a description under which you find your life to be worth living and your actions to be worth undertaking' (34, p101). Our practical identity, thereby, grounds our reasons for choice and action by explicating what we value in life. In line with this, autonomy can be understood as the expression of the different aspects of our identity in and through our actions—these aspects are, for example, being a parent, a colleague, a friend and a scuba diver, or being a person who lives healthily, appreciates culture or enjoys food.

The most important constraint on what conceptions can constitute our practical identity is an aspect we all share: our humanity. Korsgaard starts from the given that we all, as reflective beings, need reasons to endorse our inclinations and, thus, need practical identities. This becomes clearest with a concrete example. Imagine that you question a particular identity: as a

scuba diver, you may want to go to the Caribbean, but as you have recently placed a high value on your ecological identity, you question whether your identity as a scuba diver can still provide you with a strong enough reason to go. Yet, to come to a decision, you must endorse one of the two identities as reason-giving. In other words, according to Korsgaard, 'part of [the] normativity [of one's particular identities] comes from the fact that human beings need to have them' (34, p119). And the given that 'you must be governed by some conception of your practical identity' is a reason that "springs from your humanity itself, from your identity simply as a human being, a reflective animal who needs reasons to act and to live' (34, p120–21). This grounds Korsgaard's claim that not 'every form of practical identity is contingent or relative after all: moral identity is necessary' (34, p122).

It follows from Korsgaard's perspective that we must place value in our own humanity as it is what fundamentally provides us with reasons: This identity, as the reflective structure of our mind, enables us to have a conception of ourselves that grounds our capacity to value and to choose and act, that is, to be autonomous. Furthermore, as our humanity, understood as the faculty of autonomy, brings value into the world, we also have an obligation to respect this faculty in others. As they act and value acting based on their own reasons, we are obliged to respect their value-constituting capacity of autonomy in our own actions.

To summarise, Korsgaard understands autonomy as being a law unto ourselves by reflectively endorsing, at a distance to our inclinations, the principles that underlie them. This endorsement is grounded in reasons that we create ourselves by forming a conception of ourselves of which our shared humanity, our morality, is a necessary part. In Korsgaard's own words: 'Autonomy is commanding yourself to do what you think it would be a good idea to do, but that in turn depends on who you think you are' (34, p107).

#### 'BEING A MEDICAL PROFESSIONAL' AS A PRACTICAL IDENTITY

Examples of particular conceptions given by Korsgaard are that you may find it important for your life that 'you are a human being, a woman or a man, a member of a certain profession, someone's lover or friend, a citizen or an officer of the court, a feminist or an environmentalist, or whatever' (35, p20). Although Korsgaard refers here to being a member of a profession, she has not given an account of what a professional identity may consist in. For this paper, we go beyond Korsgaard and present one possible account of being a medical professional while introducing some additional elements of Korsgaard's moral theory.

First, to be a medical professional is to be a member of the medical profession that depends on some formal requirements. The medical professional must have obtained the right to practice medicine through formal training and by having a medical license from the state. The fact that practical identities have such formal requirements is endorsed by Korsgaard with the statement that 'where the facts make [the expression of an identity] impossible, the [identity] may cease to have practical force' (35, p120). As it is impossible to express oneself as a physician without formal requirements, having the identity of a medical professional is conditioned on them.

Second, fulfilling formal requirements is not enough, as these indicate solely passive conditions. The medical professional should also convert the knowledge and skills learnt into their actions, into practicing medicine. Although the exact nature of the medical professional's occupational activities is disputed, it can generally be stated that a medical professional has the good

of their patient in their decisions and actions in mind while upholding the standards as, for example, defined in the codices referred to above. The medical professional also acts towards society's welfare in preserving important common goods.

It is important to stress that any person, thus, also the medical professional, has more than one identity in Korsgaard's model. This means that the 'description under which you find your life to be worth living' (<sup>34</sup>, p101) is a pluralist description with multiple identities, such as a medical professional, parent of one's children, partner of one's spouse, hobbyist piano player, and the obligatory moral identity of your own humanity. This plurality of identities under which a person finds their life to be worth living grounds why medical professionals experience the conflicts at the margins of their profession.

### MEDICAL PROFESSIONALISM AS PRACTICAL IDENTITY: BACK TO THE CASE STUDIES

The strength of Korsgaard's framework lies in its potential to elucidate the profoundness of conflicting duties with which the medical professional is confronted. In the following, we show this by considering the three case studies described above while highlighting what action orientation Korsgaard's framework provides for solving such types of conflicts.

#### Category 1: professional ethics reaching beyond common morality/'taking a moral holiday'

From a Korsgaardian perspective, cases in which professional ethics reaches beyond moral norms pertaining to nonprofessionals can be explained as follows. By committing to the identity of a medical professional, the physician creates a commitment to uphold society's law or the profession's codices connected to this identity that reach beyond common morality that may be. Such norms that go beyond common morality are not supererogatory. This follows partially from the preconditions of being a physician, such as obtaining a medical license, that are necessary for the physician to give expression to their identity and, thus, should not be endangered. An example would be a physician who does not rescue a person in need in a nonmedical context and, as a consequence, may get their medical license revoked. This would take away their ability to practice as a physician in the future. Rescuing the person gives thus expression to an essential aspect of their identity and therewith cannot be understood as supererogatory.

Moreover, the physician—to claim that they have the practical identity of being a physician—must also apply their specific knowledge and competencies. This expresses the idea that people need to determine their commitment to an identity by acting in light of this identity. Because being a medical professional gives rise to obligations in situations where (physically and structurally) the boundaries of the healthcare setting are transgressed, this means that the physician should also give expression to their identity in such settings.

Yet, there is a question of the scope of such a duty to act outside of the healthcare setting. Setting emergency situations aside are physicians obliged to always provide medical care to nonpatients or diagnose and treat family members or friends? Within Korsgaard's moral theory of practical identities, a nonarbitrary answer can be given to this question of scope. People are not only a medical professional or a professor but also a family member, a partner of someone, a friend to others, dedicated to a hobby or a healthy lifestyle. We are, in other words, during our lives in pursuit of multiple values or identities simultaneously, and this is for most of us essential to the description under

which we find our lives to be worth living. Empirical research also confirms that the pursuit of several values in life seems beneficial for one's (mental) health.<sup>36</sup>

Yet, as we have limited resources to give expression to our identities—we only have one body and limited time<sup>37</sup>—we are required to divide our time and attention between different identities. Because of living a worthwhile and healthy life, the physician should be allowed, at times, to let go of their responsibility for people's health-related welfare. This has been called 'the need for taking a moral holiday' in the philosophical literature. Williams James was the first to point this out regarding morality in general: 'If, as pluralists, we grant ourselves moral holidays, they can only be provisional breathing-spells, intended to refresh us for the morrow's fight' (<sup>28</sup>, p228). As James indicates, taking a moral holiday does not mean losing or giving up on one's identity. It merely means to take some breathing space. Korsgaard further adds to this point: our practical identities have a stability such that they 'can take a few knocks' before the identity is no longer ours (<sup>34</sup>, p103).

Thus, within Korsgaard's theory, a limit to the scope of the physician's duties is set by their commitment to the pursuit of multiple identities and values that make their life worth living. The idea of 'taking a moral holiday' is a central aspect of this, referring to the need of all people to 'recharge their batteries' without a focus on their essential duties.

#### Category 2: professional ethics conflicting with common morality

What should a psychiatrist do when a duty to uphold medical confidentiality, an essential part of the entire medical professional, conflicts with the general duty to protect people from harm? What should a physician do when the sustainability of their practice as a duty towards future generations<sup>38</sup> conflicts with their professional duty to treat their patients in the best possible way? The medical professional is confronted in both cases with a conflict between duties coming from two sources: their identity as a medical professional and their identity as a human being in general, that is, their humanity.

Korsgaard affirms that such conflicts 'between the specific demands of morality and those of some more contingent form of identity' may exist (<sup>34</sup>, p126). Even more so, she holds that duties stemming from particular identities may trump duties from common morality (<sup>34</sup>, p128). For this to be possible, a practical identity should not be intrinsically contrary to moral value—as being an assassin would be: murdering other human beings goes, by its nature, against the humanity of the victims. Being a medical professional—whose aim is to take care of people when they cannot take care of themselves—is not contrary to moral value in this intrinsic way.

Orientation to overcome the described conflicts between professional ethics and common morality can be found in the 'deepness' of practical identities: 'some parts of our identity are easily shed, and, where they come into conflict with more fundamental parts of our identity, they should be shed' (<sup>34</sup>, p102). In other words, the deepness, or shallowness, of an identity sets a limit to the depth of the obligation that follows from it (<sup>34</sup>, p103). In the extreme, this is illustrated as follows: 'Consider the astonishing but familiar "I couldn't live with myself if I did that." Clearly there are two selves here, me and the one I must live with and so must not fail' (<sup>34</sup>, p101). Korsgaard's claim is that the deepness of an identity depends on the level of an identity's value to the person's life, not on how well it coheres with one's humanity per se.

Thus, the psychiatrist may consider the deepness of their identity as a psychiatrist and their identity of humanity. The psychiatrist can do so by asking whether not helping their client and protecting the confidentiality of the profession vs not informing the third party of a potential threat comes with stronger 'sources of reluctance' that offer 'good reasons for changing [our] mind—we do not continue to pursue an end at any costs' (34, p102). Such personal 'costs' Korsgaard refers here to such as indicated by feelings such as that we lose ourselves if we (do not) act in a specific way, letting others down, or feelings of (potential) regret. Such feelings and emotions, however, need not have a negative valence. Feelings of love and care may be more intense considering one identity than another: the psychiatrist may experience a feeling of necessity if they think about helping their client and protecting the profession's confidentiality. If one identity is deeper than the other, and, thus, the personal costs of acting against it in terms of losing what is of value in one's life is higher for them, this may give the psychiatrist orientation regarding what to do.

An alternative strategy for solving a conflict can appear by reinterpreting one of the involved identities. This may be the case for the physician experiencing a conflict between the duties of sustainability for future generations (grounded in their humanity) and ensuring the provision of reliable medical services to one's patients (grounded in their professional identity). This second duty could be reinterpreted as the duty to treat each individual patient in the best possible way not only for the immediate moment (this patient immediately in front of me), but in terms of each individual patient that the physician will encounter in their time as a physician. If one looks at the duty to treat each individual patient in the best possible way in this manner, this duty may imply the further duty to transform the healthcare system into a more sustainable practice, as this may be the best way to guarantee that each individual patient the physician will see over their career can be treated in the best way possible.<sup>31</sup> By reinterpreting their professional identity, it becomes congruent with their identity as human being, therewith giving orientation regarding what to do.

Thus, part of Korsgaard's framework is that orientation for conflicts can be found in reinterpreting one of the identities that underlie the conflict. In this specific case, by reformulating the content and meaning of professional ethics, orientation for action is provided, as the guidance of both identities becomes congruent. There is one obvious caveat here: The question whether a duty to make the healthcare system into a more sustainable practice is an actual duty of healthcare professionals is one that is determined by how the practical identity of being a medical professional is understood and lived. This kind of content, within Korsgaard's framework, cannot be determined *a priori*. Instead, it is the result of the negotiations of different stakeholders, next to the professionals themselves also including the community, within an intersubjective process to determine what a specific identity means and obliges people to do (see, eg,<sup>39</sup> Chapter 1, for what such a process may look like).

### Category 3: professional ethics conflicting with particular moralities of other origins

The examples of our third category thematise that physicians are people with several practical identities, creating multiple sources of obligations that can be in conflict with each other. Thus, if a physician feels the demand to do the best thing for their friend or to take care of their close relatives, this may bring about a conflict between these demands and the obligations stemming from their identity as a medical professional. Korsgaard's

framework offers orientation for action for these cases that is similar to the discussion of category 2.

First, orientation is gained by asking whether the considered actions are compatible with the physician's general and necessary identity of humanity. This provides an answer for the psychotherapist who feels obliged, qua being someone's friend, to do what is best for their friend and, qua being a therapist, to uphold the protocols agreed on for assigning scarce healthcare resources. In a healthcare system in which there is an underprovision of psychotherapy, prioritising one's depressive friend on the waiting list for treatment seems to conflict with the impartiality and equity grounded in the equal respect we are due to each person based on their humanity. A system for fair and transparent allocation needs to be introduced due to the scarcity of a healthcare resource. This can be explained within Korsgaard's framework based on the equal dignity of all people within the system, grounded in their identity of humanity. Because the psychotherapist with their commitment to their professional identity has committed themselves to the welfare of all the people in society and the allocation system can be grounded in the shared identity. Consequently, as all depressive people have an equal right to the scarce healthcare resource, it would go against the psychotherapist's own humanity to bypass the system to organise something for their friend. The action orientation here, therefore, asks the psychotherapist to determine whether both the actions expressive of their particular identity are compatible with giving expression to their identity of humanity. As prioritising one's friend undermines the value of humanity in oneself and others, the psychotherapist would act in contradiction to the value they necessarily place in the shared identity of our humanity if they prioritise their friend.

Regarding the physician who is conflicted between working extra shifts as expression of their identity of being a physician and taking care of their relatives as expression of their identity as a family member, both actions are compatible with their humanity. Both actions respect the humanity of the other people involved and do not in themselves undermine the system that is in place. This again introduces the deepness of identities for action orientation. The physician should thus listen to what their feelings indicate about what they would lose of value that is constitutive of who they are by (not) giving expression to their identity as a physician or as a family member. The physician can, for example, have a feeling of necessity as an expression of their love when thinking about taking care of their relatives. If one identity is deeper than the other, this gives the physician orientation regarding what to do.

Yet, having the deepness of identities does not imply that conflicts are easily overcome. Even more so, the last discussed conflict may constitute a true dilemma, as we know it from classical examples, such as Agamemnon's choice between allowing his army to cross the sea safely or sacrificing his daughter. As the physician is assumingly deeply committed to both identities that demand incompatible actions, there will always be a high cost to pay for who they are.<sup>40</sup> However, a specific strength of Korsgaard's moral theory comes to the fore, as it allows us to explain why certain conflicts experienced by medical professionals are so profound that they constitute dilemmas. As Korsgaard states '[y]our reasons express your identity, your nature' and, therefore, 'to violate them is to lose your integrity and so your identity' (34, p101). Thus, if the medical professional feels deeply torn between the obligations stemming from their identity of being a physician and those from being a parent, Korsgaard's theory allows us to explain why: Both identities are fundamental to the physician/parent's nature and violating the obligations

connected to either of them feels as if one is giving up or losing part of oneself. In other words, a physician can sometimes be truly torn by a dilemma because both of their identities are deeply embedded in and have profound meaning for what makes their life worthwhile. We take it that insofar as it is possible to conceptualise this possibility with Korsgaard's theory, it gets the physician's conflict situation exactly right.

### Limitations and strengths of the approach

Some limitations to the line of argument presented should be made explicit, while highlighting the important conclusions for which we have argued.

First, we have tried to provide a firmer grip on an inherently fuzzy topic, the margins of professional medical ethics. The fact that borders are difficult to draw clearly at these margins is reflected in the discussion of the case studies. However, we believe that Korsgaard's moral theory of practical identity allows us to conceptualise some of the ethical challenges existing at these margins in a phenomenologically plausible way.

Second, as indicated in the discussion of category 2, Korsgaard's approach cannot, by itself, provide an account regarding of what the medical professional identity consists, and, therefore, cannot provide a basis for healthcare ethics in terms of its content. However, as the discussion above has shown, Korsgaard's moral theory provides a way to ground the normativity of the professional medical ethics through the idea that a medical professional commits to the identity of being a medical professional. It is this commitment that provides and grounds the normativity to the obligations of professional ethics. This strength is only a brief reference to how the normativity of professional ethics could be grounded within Korsgaard's framework, which needs to be further explored.

A last limitation we would like to point out is that by taking practical identity as a central concept, we have shed light on some of the ethical challenges at the margins of the medical profession, but we do not claim that we shed light on all of them. One specific limitation in this regard is that Korsgaard's moral theory focuses on individuals and their commitments to certain practical identities. Professional ethics, in seeming contrast, is inherently the morality of a group, and it is necessary to let this occupational group fulfil its function in society. Moral duties of the individual physician are, at least from a certain perspective, only derived from this common social role. The collective character of professional ethics is apparently in tension with Korsgaard's notion of practical identities which individuals adapt for themselves. Yet, this tension may only be apparent. Korsgaard's theory emphasises how each of us commit ourselves to a specific identity based on what we find to make our lives valuable. It is left open, however, what a person's commitment to an identity amounts to. Such a commitment may imply that one commits to an identity of which one central defining aspect is its collective character. A person committing to the identity of being a medical professional, for example, does not have the sole authority to define what it means to take up this identity—as we have seen above, one's ability to be a medical professional is partially defined by intersubjective practices that include the medical profession as a community and society at large. Moreover, insofar as the content of an identity is defined by historical and collective processes in which individuals join together, it becomes possible to mesh Korsgaard's theory with approaches such as contractualism that are more sensitive to the 'collective ethics' of medical professionalism.

### CONCLUSIONS

We have argued in this paper that current theories of physicians' professional ethics do not have sufficient resources to capture certain moral cases at the 'margins of professionalism' and do not give clear guidance for action. Korsgaard's theory of practical identities provides such action orientation, supporting medical professionals to structure conflicts they experience at the margins of their practice and allow them to make decisions.

Moreover, insofar as the analysis of such cases from the perspective of Korsgaard's moral theory is unable to provide orientation, it is able to give an account of why such moral conflicts give profound and troubling experiences, sometimes even being moral dilemmas. The acknowledgement of dilemmatic or tragic situations that professionals might experience and their distinction from less desperate moral conflicts is a major prerequisite for dealing with 'hard cases.' Korsgaard's theory, thus, offers us a helpful explanatory framework for a deeper understanding of moral issues at the 'margins of professional practice'.

Lastly, the multiple social (and moral) roles in which physicians find themselves should be adequately considered in healthcare regulation and practice. Multiple normative affordances pertaining to physicians should also be acknowledged in professional codes of ethics. As moral challenges 'at the margins' of professional practice are manifold and occur frequently, they need to be adequately addressed in appreciating the various practical identities to which physicians commit themselves.

**Contributors** Both authors developed the study concept and co-wrote the article. Both authors approved the final manuscript and its revision. SS is the guarantor.

**Funding** The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

**Competing interests** None declared.

**Patient consent for publication** Not applicable.

**Ethics approval** Not applicable.

**Provenance and peer review** Not commissioned; externally peer reviewed.

**Data availability statement** No data are available.

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