

This Year's Bioethicist: From Influencer to Prophetic Educator

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Advocates, Activists, Architects of Moral Space?

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Article abstract

Professional bioethicists have gained increasing acceptance in the healthcare and academic communities of the United States over the last 50 years. However, since the current administration took office in January 2025, questions concerning the appropriate role of bioethicists in preserving the values and ethics of healthcare and academic institutions have abounded. I argue that the usual tripartite characterization of service, scholarship and education still apply but how we interpret those roles and their relative importance has changed. While our established role of influencers of institutional policies remains important, the climate of fear-induced silence challenges us to emphasize our prophetic voice in calling the healthcare professions and institutions to remain faithful to their fundamental values. Furthermore, I recommend a renewed emphasis on basic education of professionals to solidify their formation.

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TÉMOIGNAGE / PERSPECTIVE

This Year's Bioethicist: From Influencer to Prophetic Educator

Mark Kuczewski^a

Résumé

Au cours des 50 dernières années, les bioéthiciens professionnels ont été de plus en plus acceptés dans les milieux médicaux et universitaires aux États-Unis. Cependant, depuis l'arrivée au pouvoir de l'administration actuelle en janvier 2025, les questions concernant le rôle approprié des bioéthiciens dans la préservation des valeurs et de l'éthique des établissements médicaux et universitaires se sont multipliées. Je soutiens que la caractérisation tripartite habituelle du service, de la recherche et de l'éducation reste valable, mais que notre interprétation de ces rôles et de leur importance relative a changé. Si notre rôle établi d'influenceurs des politiques institutionnelles reste important, le climat de silence induit par la peur nous oblige à mettre l'accent sur notre voix prophétique pour appeler les professions et les institutions de santé à rester fidèles à leurs valeurs fondamentales. En outre, je recommande de mettre à nouveau l'accent sur l'éducation de base des professionnels afin de consolider leur formation.

Mots-clés

liberté académique, EDI, peur, influenceur, immigration, professionnalisme, représailles

Abstract

Professional bioethicists have gained increasing acceptance in the healthcare and academic communities of the United States over the last 50 years. However, since the current administration took office in January 2025, questions concerning the appropriate role of bioethicists in preserving the values and ethics of healthcare and academic institutions have abounded. I argue that the usual tripartite characterization of service, scholarship and education still apply but how we interpret those roles and their relative importance has changed. While our established role of influencers of institutional policies remains important, the climate of fear-induced silence challenges us to emphasize our prophetic voice in calling the healthcare professions and institutions to remain faithful to their fundamental values. Furthermore, I recommend a renewed emphasis on basic education of professionals to solidify their formation.

Keywords

academic freedom, DEI, fear, influencer, immigration, professionalism, retaliation

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INTRODUCTION

The climate in which US healthcare institutions and universities operate has changed so dramatically since January 2025 that nothing seems the same. These institutions are now under a plethora of pressures that had previously seemed unimaginable. For instance, efforts to promote diversity, equity, and inclusion (DEI) are suddenly feared to place these institutions at risk of investigations and withholding of federal funding. And exercises of the basic freedom of institutional representatives and employees, including professors and students, to express opinions regarding matters such as the human rights of Palestinians can lead to similar consequences in addition to revocations of student and faculty visas, detention, and deportation.

When fear is so pervasive, clear, consistent reasoning concerning moral obligations can be difficult to attain. And rational internal dialogue about policy and ways of proceeding can be eschewed in favour of a risk management strategy of whispering among a very small number of administrative leaders. While this environment is very different from the world in which US bioethicists have thrived for the last 50 years, I believe that bioethicists have the skills and a calling to play important roles within it. I have elsewhere articulated the bioethicist's main role as one of a behind-the-scenes influencer (1,2). However, in a climate where truth is oftentimes suppressed, we must summon the courage to use our voices prophetically and our educational platforms to call healthcare professionals and institutions to truth-based advocacy for patient populations who are unjustly demonized. In other words, bioethicists must build upon our role as institutional influencers and do our work in a more public and educationally engaging manner. I will refer to this role as that of the bioethicist as prophetic educator.

WHAT HAS THE BIOETHICIST'S WORK TYPICALLY LOOKED LIKE?

Bioethics has ancient roots, but its professionalization is relatively new. Questions related to medicine and life and death decisions have been discussed by philosophers at least since the time of Plato's Republic and has a storied history among physicians (3). But the existence of professionals who work in multidisciplinary centres, consult with clinicians and patients at the bedside, engage in fostering ethically compliant biomedical research, and provide recommendations on organizational policies is a phenomenon that began in the second half of the 20th century. Such professionals are still sufficiently few in number in the US that we might better be thought of as an epiphenomenon relative to the massive healthcare establishment. Nevertheless, bioethics has been successful in establishing an awareness of the ethical dimensions of much of clinical practice and biomedical research. This awareness has influenced institutional practices.

Bioethics has provided ordinary, everyday responses to the dramatic. The field has sometimes received impetus from high-profile cases that capture national attention, such as the famous end-of-life cases of Karen Ann Quinlan and Nancy Beth Cruzan, and from scandals that cry out for new safeguards such as the coming to light of US Public Health Service (USPHS) Untreated Syphilis Study at Tuskegee. But when the dust settles, these issues — as they manifest in hospitals, clinics, and laboratories across the country — are ameliorated by things such as improved communication and shared decision-making procedures or increased oversight by multidisciplinary committees. Such approaches do not deny the profundity of the life issues and mysteries involved. But bioethics often makes the issues manageable through routinization of processes. The successful bioethicist sometimes keeps their institution out of the media spotlight through this management of difficult decisions.

I have suggested elsewhere that this method of operation has often allowed bioethicists to gain significant influence in their healthcare and academic institutions (1). Initial suspicions that bioethicists might be “loose cannons” who embarrass their institution through public crusades about the institution’s behaviour or insistence on unrealistically idealistic goals have been overcome. We are often seen as trusted colleagues who have the dual value of managing problems while also reinforcing the integrity of healthcare providers and institutions. Who wouldn’t want a little bit more of that?

This kind of institutional political capital enables a bioethicist to sometimes raise new issues and influence an appropriate response to developments that might otherwise escape the notice of clinical leadership. For instance, in 2024 the state of Florida mandated that hospitals ask patients their immigration status during the admission process. This kind of requirement might not seem terribly important to high-level hospital administrators, and they could unthinkingly delegate its implementation to hospital compliance officers. However, bioethicists called attention to the potentially “chilling effect” on seeking care that this requirement would likely have on patients who are immigrants to the US (4). They were supported by a statement from the Association of Bioethics Program Directors (ABPD) that highlighted the threat to the identity of caregivers and caregiving institutions from carrying out this mandate (5). This statement provided documentation that individual bioethicists could use to demonstrate to their institutional leaders that they were not raising idiosyncratic concerns. While each institution must comply with the law, the work of bioethicists within their institutions often led to creative approaches to mitigating the harmful effects of asking the question, including creating welcoming and explanatory signage and engaging in widespread patient and community education. Bioethicists acted as influencers of institutional awareness and policy to bring about a more ethical and just outcome. While this may seem a mundane example, how to respond to a requirement that ran counter to the values of healthcare professions and institutions was a high-stakes discussion, because seeming to resist the requirement could potentially jeopardize an institution’s Medicaid reimbursement from the state. This issue presaged the current national political environment (6).

HOW HAS THE WORK CHANGED IN THIS EXTRAORDINARY ENVIRONMENT?

As the example of the Florida anti-immigrant law indicates, there are ways in which the skills of bioethicists are suited for the kind of work that is currently needed. For instance, bioethicists are well-suited to highlight the professional identity and ethical issues that are at stake from federal pressures such as those being exerted to undermine DEI efforts, to forgo various types of research, and to cooperate with immigration enforcement officers. Using our accumulated internal political capital, we’re usually able to help institutional leaders to understand the necessity of crafting paths forward that continue to honour their core values to the fullest extent possible.

What is new to the environment is the widespread fear among institutional leaders that their institution may be perceived by government authorities as resistant to the imposition of their desired policies. As I previously noted, I first saw this at the state level in the case of the Florida required-ask policy. Administrators sometimes expressed fears of retaliation from the state government, such as delays in Medicaid reimbursement, if they came to be seen as hostile to the policy. Such retaliation could even be an existential threat to facilities that do not have a large number of days of cash on hand. In this kind of fear-filled climate, bioethicists have good reason to consider whether their usual method of operation is sufficient.

The bioethicist’s usual mode of operation assumes a social context in which free speech is generally taken for granted. A threat to long-held professional and institutional values must be addressed on the reflective level of the self-understanding of professionals and institutions in addition to the clinical level. Professional values and identity can easily erode if threats are not recognized and highlighted. As the name “profession” indicates, values must be professed in an ongoing way. This is a basic aspect of collective and individual professional identity formation. In the US, we have traditionally expected that institutions and professional organizations will vociferously represent their concerns in the public square. But this assumption has been surprisingly easily undermined by fears of retaliation.

In the Florida case, the values at stake as well as the practical implications for public health from asking patients their immigration status were articulated by the ABPD, the American College of Physicians, and some specialty news organizations (5,7,8). The lack of statements by Florida’s medical societies and major health systems was conspicuous. It fell to organizations outside of Florida to articulate the threat as professional organizations and institutions within the state felt at risk. If it were not for these national organizations illuminating the threat to the professional identity of Florida’s healing professions, it would have been possible to “to unwittingly sleep through subtle changes that erode the mission of our health care institutions.” (4)

When the threat comes from the federal government, there are no US professional organizations and institutions outside the reach of retaliation. When fear of retribution is nationwide, a kind of values somnambulism could easily become the order of the day. In this new era of potential retaliation from state and federal governments, bioethicists have an enhanced duty to identify challenges to the identity and values of healthcare professionals and institutions and to publicly articulate them. We must aim to foster reflection rather than accept moral sleepwalking. This duty may be in some tension with our behind-the-scenes influencer roles in our respective institutions.

BIOETHICISTS AS PROPHETIC VOICES AND EDUCATORS

In the current sociopolitical context, key values and ethical tenets of the healing professions and institutions could be easily eroded without widespread notice if bioethicists restrict themselves to their institutional role as influencers. We may accomplish some positive benefits within our institutions but even those would be more difficult without being able to publicly anchor the issues in terms of established norms of professional ethics. While steering protocols in an ethical direction is important, without a widespread understanding of the rationale, mistaken, even harmful conclusions may be drawn by key stakeholders.

For instance, some of our institutions may take some symbolic steps such as to roll back the language of DEI (“rebrand”) as a way to avoid governmental scrutiny and retaliation while retaining the moral substance of DEI programs, e.g., correcting for structural bias and seeking to provide fair opportunity to previously excluded persons. Unfortunately, in a climate of fear-induced silence, observers, including staff and patrons of our institutions, may conclude from the linguistic change that a fundamental value shift has been embraced. This might facilitate professional identity malformation because it would be reasonable to conclude that the institution now sees its former position as mistaken or perhaps simply not important.

In an environment where healthcare institutions, colleges and universities, and professional societies have been muted regarding the negative implications for their missions and identities, moral truth itself can become a casualty. As a result, the bioethicist has a duty to articulate the truth regarding the values at stake, the duties of the professions, and the missions of healthcare and academic institutions that are threatened by new governmental policies. The bioethicist must become a prophetic voice, or less dramatically a moral educator.

Catholic writer Michael Sean Winters tells us that a “prophet does not simply point to some future of his or her own imagining. A prophet calls a people to return to their truest selves in order that they may return to a righteous path.” (9) In other words, the prophetic voice in healthcare and academia is one that calls out on behalf of the fundamental values of professional identity. The moral truths being obscured by politics and intimidation are again illuminated.

A simple and inspiring example of this can be seen in an editorial in the American Journal of Bioethics entitled “Bioethicists Must Push Back against Assaults on Diversity, Equity and Inclusion.” (10) This essay does exactly what its title calls for. The authors explain the ethical justifications for DEI, describe several kinds of efforts that fall under that descriptor, and dismantle the main critiques of DEI being advanced currently. These authors are not simply “taking a stand” in the political sense. They are calling for holding fast to policies that advance the values of healthcare professionals such as respect for the dignity of all persons. Such a piece is prophetic in the sense of illuminating the moral truths contained in DEI efforts, calling for professionals to be true to their identity, and thereby advocating for health of the communities that healthcare professionals serve.

Scholarship that advances the values of healthcare professionals and institutions, whether original data gathering or perspective pieces that develop an argument based on accumulated data, is clearly an important aspect of the bioethicist’s prophetic role. Bioethicists also make a valuable contribution when they promote such arguments and conclusions in trade and popular media. This is also a part of the educational vocation of bioethicists.

THE DUTY TO EVERYDAY PROPHETIC EDUCATION

I would like to suggest that we have often underestimated the moral importance of our educational role. As I have illustrated, there are many important ways that bioethicists can service moral truth, such as through consensus statements of the Association of Bioethics Program Directors, scholarly articles, contributions to popular publications, and by our role in influencing institutional policy. While such efforts are quite laudable and important, we should also ask ourselves how we can do more to directly educate healthcare professionals and assist their professional ethical formation. For instance, have we done talks on key issues for our colleagues in their common continuing education venues, such as grand rounds? These educational venues provide an opportunity to pierce the institutional silence in an informative way that is not especially threatening. Such presentations are expressions of our academic freedom and are not a statement by the institution. Furthermore, such presentations have their own important sphere of effectiveness.

My work has largely focused on supporting patients who are immigrants to the US. It is an area that is opaque to most Americans, including many healthcare professionals. Immigration is perhaps the most politicized issue of the present era and misinformation abounds. We have witnessed a ceaseless vilification of these patients as criminals and as people who unjustly use benefits to which they are not entitled. We have even watched them be characterized as some kind of subhumans who eat their neighbours’ pets (11). Because this population is so widely demonized in our politics, healthcare professionals (and most Americans) need basic knowledge and attitudinal education.

In this environment, I usually begin my talks on serving immigrant patients by reviewing the basic values of the healing professions. These values apply to the care of all patients. In order to secure a least common denominator among those of varying attitudes toward immigrants, I sometimes consider how professionals deal with any patient who they think may have committed a crime. I reinforce the common institutional protocols. For instance, if the patient poses no immediate danger to others in the clinic and the suspected crime is not mandated by law to be reported, healthcare professionals and their institutions generally see the duty of patient confidentiality as paramount. Healthcare institutions generally require a warrant signed by a judge to disclose information about that patient and would discipline staff who contacted law enforcement on their own. This lays a baseline that establishes that all staff must treat immigrant patients primarily as patients.

Once one establishes clearly that the vocation and mission of healthcare professionals must be to treat patients and to address obstacles to accessing timely and effective health care, other kinds of support become clearly appropriate. For instance, reassurances that the clinic respect patient privacy and not cooperate with immigration authorities unless compelled by a judicial warrant are expressions of the healing mission, not politics. Similarly, offering information regarding other available social supports such as reputable legal resources are about empowering patients to move beyond fear and take positive steps that are supportive of their mental and physical health.

I also raise the historical analogy to treating patients who are Black during the era of Jim Crow in the US. I ask them to consider what the obligations of the medical profession are when patients are routinely characterized as inferior and segregated from other Americans and opportunities to achieve a full and healthy life. This line of discussion suggests that the healing professions' commitment to the dignity — literally, the worth of each person — raises some additional duties, such as fostering the truth of human equality and the contributions to society of these neighbours and colleagues. Following out of such lines of reasoning in educational sessions is an effort at professional formation — developing and refining the virtues of these professionals.

CONCLUSION

What these times require of bioethicists is not so different from what we have long been doing. In past years, I have argued that we underestimate our service role as institutional influencers. As influencers, we can affect many lives through organizational policies and clinical protocols. I have not always placed the same emphasis on matters such as public statements and scholarship. But this year, the bioethicist must preserve the space for the fundamental values of the healing professions and institutions by giving voice to those values and illuminating how they are being threatened. I have adorned this role with the noble metaphor of the prophetic voice because of its place in calling our colleagues to what is best in their professional traditions.

I have followed this somewhat grandiose characterization with a request that bioethicists execute this noble function in the most mundane of ways — by doing presentations in everyday educational venues. Sometimes prophetic voices cry in small venues if not completely in the wilderness. I believe that this work is essential because articles and position statements are often not widely read or only read by those who are expert on the topic. We must also build from the ground up. Professional formation often takes place within one's immediate learning community. Promulgating and reinforcing the cherished values of the healthcare professions in those communities is a foundational moral activity.

In closing, it is clear that I have not answered many of the questions that will continue to be urgently discussed among bioethicists. In a sense, I have said little more in response to the question of what this year's bioethicist should do than to answer: service, scholarship, and education. However, I have tried to show the urgency to carry out these functions and the significant stakes in doing so. We will continue to come under pressures to not discharge these functions. And the need of the professions and society for this kind of work is far beyond the capacity of bioethicists alone. But we would not be worthy of the name of our profession if we did not do all we could to advance these goals.

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