Title: Towards a dialogical ethics of interprofessionalism[1]

Author(s): R. Irvine, I. Kerridge, J. McPhee

Abstract

Contemporary medical practice brings a diverse range of professions and disciplines together in greater and closer contact. This situation of increasing complexity and changing professional roles gives rise to multifaceted ethical dilemmas and theoretical and practical concerns. In this essay we argue that for multidisciplinary relationships to be facilitated and to progress towards interdisciplinary teamwork, moral agents have to go beyond orthodox ethical systems and appeal to normative theory. We will argue that conceptualising ethics as a shared social practice may provide a useful starting point. This dialogic approach places greater emphasis on open deliberation and the articulation, negotiation, exploration and generation of new ethical perspectives in the here and now of clinical practice.

One of the most significant changes to have occurred in the delivery of health care over the last 40 years is the expansion and diversification of health care labour. Today, hospitals, clinics, and public health programmes are staffed by highly differentiated but mutually dependent professionals who constantly interact with and affect each other.

The desire of all health care providers for treatment to be efficacious and safe provides a necessary reference point for interaction and collaboration. So they may share language, approaches, materials and therapeutic strategies. But it is also possible to find points of contrast within and between professional groups. Professionals differ in the kinds of knowledge and skills that they contribute to the production of favourable patient outcomes; the interests that they pursue; and the kinds of questions and problems that they deem important. They come from different traditions rooted in history with their own distinct moral heritages and accustomed ways of ensuring moral accountability.

Multidisciplinary relationships are also political. The contemporary story of much of health care practice is one of different occupational groups establishing clear professional demarcations and demanding that their expertise to be recognised.[1] To this end they construct their own distinctive, occupationally specific codes of ethics and advance what they deem to be their own ethical theories, for example 'medical ethics' against 'nursing ethics', which articulate a plurality of ethical visions and moral systems.

Contemporary ethics discourse

In the face of this complexity, recent ethics textbooks published in the West and aimed at medical students and practitioners seem to rely on two or three common approaches or theories within which inquiry is enclosed.[2],[3],[4]

The first frame of reference emphasises the role of universal principles in directing moral behaviour and action. Autonomy, beneficence, non-maleficence, justice and self-determination commonly are taken as the foundational criteria based on which medical practices, and the moral adequacy of those practices, are grounded, ordered and vindicated.[5] Another approach, utilitarianism,

---

[1] This is a publisher-produced copy of Irvine R, Kerridge I, McPhee J. Towards a dialogical ethics of interprofessionalism. J Postgrad Med. 2004; 50(4):278-80, available from:
http://www.jpgmonline.com/text.asp?2004/50/4/278/13648
This work is licenced under a CC BY 4.0, https://creativecommons.org/licenses/by/4.0/ .

emphasises the importance of professional agents attempting to achieve the best possible good for the greatest number. A third approach enumerates the ideal moral characteristics (or 'virtues') that the 'good doctor' is to embody.

These perspectives clearly appeal to academic writers, theoreticians and clinicians as a means of imposing moral order and governing conduct and social interaction. Codes of professional ethics commonly articulate elements of each.

Ethical issues and multidisciplinary practice

Orthodox ethical endeavours may be inadequate for the conditions of multidisciplinary health care practice. Health care providers are apt to have well-formed ideas about what makes proper professional practice and professional relationships. Prescriptive ethics, particularly those that are based on the idea of an a priori universal framework of judgement tend to promote the idea that only one form of professional life is legitimate and acceptable. The effect of this hierarchically ranked order of pre-determined values and principles is to deny the normative relevance of other frames of reference. The voices, situated experiences, ethical discourses and standards of evaluation of other occupational groups are seen as lower, more primitive, or less rational and therefore unacceptable.

Indeed, traditional approaches to morality may pose an ethical threat to the development of interdisciplinary team relationships. This is particularly the case with virtue-based approaches to professional ethics. For example, it is not uncommon to find professional ethical discourse taking the form of an evolutionary account of moral and ethical development. In this discourse, the presumption is that one's own professional standards have reached the highest stage of moral development. These virtues are then used as the standard against which other professions and other forms of professional life are judged, usually to their disadvantage and the benchmark to which all practices must conform.[6]

Professions, like colonial powers, often attempt to impose their will upon different or opposing ethical systems.[7] Because each profession's standards are imagined to contain the essence of rational thought and professional virtue that is foundational, they are unable to acknowledge the contribution that rival moral frameworks might make. Rather they risk being adjudged dogmatic and in need of assimilation.

If not acted upon, these fault lines may diminish the capacity of health professionals to bridge different value systems and meaning contexts and develop positive relations with one another.[8],[9] For example, in 1980 Kundstader observed that one of the key issues confronting physicians and ethics was the failure of practitioners to listen to others whose voices were at odds with their own moral and value frameworks.[10]

Although exhortations to cooperate have been numerous, little seems to have changed over the intervening years. Institutionally and culturally, relationships between health care professionals remain fraught with organizational, status and value differences. For example, an Australian survey of hospital admissions reported that problems with professional interactions were the most common cause of preventable disability or death and were twice as common as those due to inadequate medical skill.[11] Similar findings have been reported elsewhere in the Australian literature.[12]

The point that we would like to make here is that the problems that arise in multidisciplinary settings are unlikely to admit to a single solution. The differing ways in which health care professionals interact along with the different moral frameworks that they bring to the encounter make it tricky to impose a uniform set of abstract principles. Fashioning the ethical foundations for

the deeply complex patterns of multidisciplinary relations and morality would seem to require more imaginative forms of ethical reasoning.

Paul Komesaroff's deployment of what he terms 'microethics' should be seen as a significant attempt to reframe the way that ethics is understood in contemporary medical settings. Drawing from his everyday ongoing clinical practice, Komesaroff identifies clinical encounters not simply as the essence of medical practice but the ground to rethink ethics.[13]

One of the most general insights to be derived from his relational ethics is the notion that ethical thought in the clinical context involves a social element. Ethical deliberation is conceived as a historically situated, two-sided practice characterized by participants doing their utmost to achieve mutual understanding. This approach to ethics seems especially appropriate to multidisciplinary health care environments. In this view ethical consideration is extended from the professional moral agent to the diverse experiences and perspectives of all participants in the clinical encounter. In this way it broadens the idea of the moral community beyond the boundaries of the single profession.

An outline of a dialogic approach to medical ethics

The approach that we advocate here largely compliments Komesaroff's microethics, but there is an additional element: it places a greater emphasis on dialogue. Dialogue plays a central role in most every aspect of medical practice.[14],[15] Or so it would seem. The following discussion sets out the basic elements of a dialogic approach to ethics.

Dialogic ethics is organized around an extended notion of collegiality. It presupposes that all credentialed health care professionals are indispensable co-participants in a relationship of exchange. Participants are accorded equal opportunity to freely express their beliefs, values, traditions and perspectives. We maintain that professionals of all stripes stand to gain from engaging the perspectives and ideas of rival conceptions rather than being driven by the logic of their own particular category of professional moral knowledge. It may produce new, possibly hybrid, systems of ethical thought and moral standards that are appropriate to today's multidisciplinary health care environments.

We know that incompatible values and conflicting expectations of the 'right thing to do' can be found at most every juncture of the treatment process. Ideals, moral concerns, evaluative standards and experiential perspectives 'outside' established patterns of judgement and understanding that strike some as understandable and important may be regarded by others as incompatible with their own values and systems of meaning. Orthodox ethical discourses tend to obscure unspoken diversity and cover over moral conflict with rather bland absolute and universalistic norms.

Traditional approaches stand in open contradiction to dialogic ethics. Although consensus is something which participants may aim in the exchange, dialogic ethics does not stipulate mutual agreement as a necessary precondition for exchange. Rather, it acknowledges and accepts the possibility of conflict between moral discourses and ethical systems within an ongoing process of negotiation. This is not to suggest that dialogic encounters never result in consensual agreement over common standards of evaluation for judging practice, knowledge, beliefs, and conduct. However, consensus is understood as something that is constructed discursively from the bottom up. Universality and particularity may therefore figure in the new vantage point.

Ethics discourse and professional identity formation

Professional ethics education customarily aims at fostering ethical improvement in students and the establishment and maintenance of better forms of 'professional life'. Shaped by the press of historical and cultural contingency the student's individual subjectivity is fashioned through the internalisation of specialist knowledge, technique, values and belief. Through this process of

professional socialisation, the neophyte physician comes to think of herself or himself as being a particular kind of person; a bearer of the profession's values, standards and norms.

Professional 'identity stories' commonly construct a philosophical and social image of the professional subject as a fully aware agent, a person who is both self-controlling and self-reflexive. That is, a person who engages in critical reflection and self-examination. To this end, a professional person is meant to consciously submit self-evident forms of professional knowledge, moral reasoning and clinical practice to detailed scrutiny and evaluation.[16] And to evaluate the adequacy of his or her actions against the moral intentionality of his or her own professional culture. However, because of the discursively exclusionary nature of professional communities, it often seems to be the case that professional views and practices remain methodologically immune to such critical forms of interrogation and analysis.

It is in relation to this project geared to the cultivation of a self-critical moral agent that dialogic forms of ethical reasoning have the potential to play an especially productive role. For dialogic ethics, and its attendant forms of ethical subjectivity, is neither passive nor unreflectively accepting of the status quo . In what Nandy termed a 'dialogue of visions', dialogic ethics creates a space for self-reflection beyond what is known and familiar.[17] It is the relationship with others and not simply one's profession, with its shared moral values and regulative norms that is the anchor point that constitutes the critical foil against which one's ethical theory and moral practice is opened to scrutiny.

Dialogical professional ethics rests on the participants providing an account of their conduct and behaviour to others. Commonly accepted principles, values and standards of evaluation which condition decisions and activities of everyday ethics are brought into the open for others to criticize and articulate their own point of view. In striving for mutual understanding, moral subjects must account for and justify the kind of ethical reason that they use.

Those who are prepared to engage in this enterprise, particularly those with greater power, stand to gain genuine insight into what their practice looks like from the outside. This in turn provides professionals with an opportunity to understand and experience themselves anew and to think differently, in a deeper way about the ethics of their moral practice.

Conclusion

Multidisciplinary practice in contemporary health care settings is a complex terrain which requires a little imagination to negotiate its intricate moral and ethical challenges. Our suggestion is that taking a dialogical approach to ethics may enable connections to be made with other professions which correspond with the kinds of relationship we seek with disciplinary colleagues.

Establishing dialogical relationships is challenging for individuals, professions and institutions and demands a great deal of 'ethical work'. So too is remaining open for new and contesting voices because professional agents are required to reassess the power imbalances that are a feature of contemporary health care delivery. These are no small tasks, but they are unavoidable if interdisciplinary and interprofessional teamwork is to have any real meaning.

References

1. Abbott A. A system of professions: an essay on the division of labour. Chicago: University of Chicago Press; 1988.

2. Campbell A, Gillett G, Jones, G. Medical Ethics. 3rd ed. Melbourne: Oxford University Press; 2001.

3. Dickensen D. Risk and Luck in Medical Ethics. Cambridge: Polity; 2003.

4. Gillon, R. Philosophical Medical Ethics. Chichester: John Wily and Sons; 2000.

5. Evans, M. Critical Reflections on Medical Ethics. Stamford Conn: Jai Press; 1998.

6. Shenkin HA. Medical Ethics: Evolution, Rights and the Physician, Kluwer. Dordrecht: Academic Publishers; 1991.

7. Nandy A. Traditions, tyranny and utopias: essays in the politics of awareness. Delhi: Oxford University Press; 1992:6

8. Dickensen D. Risk and Luck in Medical Ethics. Cambridge: Polity; 2003.

9. Gillon, R. Philosophical Medical Ethics. Chichester: John Wily and Sons; 2000.

10. Kunstadter P. Medical ethics in cross-cultural and multi-cultural perspectives. Soc Sci Med 1980;14B:289-96.

11. Donchin Y, Gopher D, Olin M, Badihi Y, Biesky M, Sprung CL, et al. A look into the nature and causes of human errors in the intensive care unit. Crit Care Med 1995;23:294-300.

12. Australian Health Ministers' Advisory Council. Final report of the taskforce on quality in Australian health care. Canberra: Australian Health Ministers' Advisory Council; 1996.

13. From bioethics to microethics. Ethical debate and clinical medicine. In Komesaroff P, ed. Troubled bodies: critical perspectives on postmodernism, medical ethics and the body. Melbourne: Melbourne University Press; 1995.

14. Zaner RM. Medicine and dialogue. J Med Phil 1990;15:303-25.

15. Little M, Jordens C, Sayers EJ. Discourse communities and the discourse of experience. Health 2003;7:73-86.

16. Foucault M. The use of pleasure: the history of sexuality v. 2. London: Penguin Books; 2003, p.8-9.

17. Nandy A. Traditions, tyranny and utopias. Essays in the politics of awareness. Delhi: Oxford University Press. 1992, p.17.