

**A Theoretical Foundation for Interprofessional Healthcare Ethics Education**

by

**Erin M. Johnson**

BA, Columbia University, 2006

MD, Case Western Reserve University, 2010

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This thesis was presented

by

**Erin Margaret Johnson**

It was defended on

October 27, 2019

and approved by

Dr. Lisa S. Parker, PhD, Professor and Director, Center for Bioethics and Health Law

Dr. David Orenstein, MA, MD, Faculty Emeritus, Center for Bioethics and Health Law; Janet  
Palumbo Professor of Cystic Fibrosis of the School of Medicine

Dr. Bridget Keown, MA, PhD, Lecturer, Gender, Sexuality and Women's Studies

**Thesis Advisor:** Dr. Lisa S. Parker, PhD Professor and Director, Center for Bioethics and Health  
Law

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Erin Margaret Johnson, MA

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The modern medical care team in the hospital setting is a complex marriage of various medical professions, who work together in the confines of a traditional hierarchy of power. At the same time, these professionals are largely educated and trained in a siloed manner, including their ethics education. This thesis argues that employing a mandatory, interprofessional and interdisciplinary ethics education of both pre-professional and post-professional medical care providers may lead to a more nuanced and comprehensive approach to healthcare. Using the lens of feminist social epistemology's concepts of situated "knowers" and Standpoint Theory, I argue that each student or learner may aid in the furthering of another's ethics education. With regard to particular patients, such an approach may elicit and more fully incorporate a patient's narrative and perspective, and may also consider multiple aspects of a patient's care. In this way a healthcare team would be able to deliver more ethical care and higher quality healthcare. This approach may also further facilitate transparency within the medical team by bringing together all care team providers so that they are equally privy to the same ethical grounding and vocabulary, and share in learning the ethical implications of medical advances. A related, important benefit would also be enhancement of team communication, as such an educational structure counters a long-held culture of hierarchical practice and rigid divisions of labor within medicine. Such hierarchy and division of labor often create barriers to communication, which can then undermine ethical care and exacerbate emotional and moral distress amongst care team members. This thesis asserts that

between a more nuanced ethical education and improved communication within the medical team, care team members may reduce their frequencies of experiencing emotional and/or moral distress. There are many complexities and challenges that face implementing an interprofessional approach of ethics education, due to limitations of geography, funding and scheduling. However, the use of communication technologies such as skype may aid in circumventing such barriers to implementation.

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## 1.0 Introduction: The Hierarchical Structure of the Contemporary Healthcare Team

During the 20<sup>th</sup> century, the modern concept of the “healthcare team” emerged, and the membership of such teams expanded steadily. Sub-specialization within medicine resulted in the current system where a patient is often treated by not just one but a number of physicians, depending on the scope of illness or injury. Division of expertise also led to the creation and growth of medicine-associated fields of learning and practice: dentistry, psychology, nursing, pharmacology, etc. Within a hospital, no patient receives medical treatment by just one person. Rather, every patient has a care *team* of health professionals who bring specialized skills and services to a patient. Because the topic of this paper is medical education and continuing medical education (CME), the discussion will focus on the inpatient setting of the medical/surgical hospital, as a large amount of medical education and CME occurs in this setting.

Although healthcare delivery is largely fractured as described above, there is still often a hierarchical approach to healthcare delivery in the hospital setting. A “healthcare team” is classically envisioned as a group of professionals – led by a captain or head, the attending physician. These professionals work to carry out the attending physician’s prescribed treatments or provide the physician with the information and insights needed to issue such prescriptions. These assisting providers may be those who carry out the physical labor of medicine. Examples of such providers are nurses placing IVs and administering medications, respiratory therapists providing breathing treatments, or physical therapists stretching limbs. These assisting providers may also be consulting physicians who provide expert analysis and suggestions to the attending physician. Again, ultimately it is the team captain who has the responsibility and right to direct the care plan in conjunction with the patient. Increasing this complexity is the addition of trainee

providers who do not have ultimate authority over a patient's care, but at times are delegated some authority over the "assisting" providers. For example: an attending physician might decide in the morning that a patient should diurese one liter of extra fluid off of his body during the course of the day. The attending gives this plan to the team, though the responsibility of the plan's implementation may be delegated to the trainee physician. The trainee then chooses the medication and dosing regimen and directs the nurse (or nurses, given the shift basis on which nurses staff the healthcare setting) to administer said medication to reach the goal of diuresis.

This particular team structure may lead to friction or conflict within the medical care team, including in teaching medical centers. Often trainee physicians are transient members of the team, joining for a number of weeks or months before leaving. The attending physicians and assisting clinical staff develop their relationships over months or years of working with each other, even if this work is not on a daily basis. Nurses and other assisting clinicians - such as respiratory therapists - often have greater depths of both knowledge and experience than trainee physicians, although these clinicians are officially bound by the physicians' orders. This fund of experiential knowledge, coupled with their long-standing roles within a team, may place them in a position of greater power than the trainee physician, even when the trainee physician is technically placed above them by official hospital hierarchy.

Beyond the friction that can exist within a specific specialty healthcare team secondary to inherent hierarchies, there is also friction that occurs within a patient's greater medical care team in the hospital when the team is composed of various specialties. Specialties within medicine wield differing levels of power and command varying degrees of deference. Such differences may be connected with the amount of training or research required to attain "board certification" in a particular field - a pediatric cardiothoracic surgeon undergoes ten years of training and research

to reach the attending level, whereas a general pediatrician undergoes three years only. Differences may also be tied to a specialty's earning potential for the medical institution – a neurosurgeon performs not only emergent but also elective surgical cases in a hospital, and these cases in turn provide work and billing opportunities for anesthesiologists, intensivists, neurologists, and the hospital facility itself. There also is a certain degree of prestige and power associated with the use of medical technology. By nature of their specialty, intensivists and anesthesiologists do not recruit patients for their care, and so are dependent on emergencies and surgeons' elective cases for business. Although there can be many specific hierarchies resulting in conflict within the academic medical setting, this discussion will focus on the general concept of hospital hierarchies, and the intrateam friction and communication difficulties that arise in the hospital setting.

Each member of a medical team enters into the hospital following fairly siloed educational experiences. Each profession has its own separate “school” and course of study, whether it be at an undergraduate or graduate level. These programs of study often have courses in bioethics that reflect the ethical perspective of the particular profession. The class might be taught by an individual outside of the particular healthcare profession – at times even by a professional ethicist – but it usually does not involve bringing together an array of pre-professional students or educators of various professional backgrounds. Furthermore, there is great variation in the structure and content of ethics education within each field, and between fields. The only commonality in this education since the latter half of the 20<sup>th</sup> century has been a widespread adoption of teaching some form of Principlism (namely Beneficence, Nonmaleficence, Justice and Autonomy) first in medical schools and then nursing schools. (Beauchamp and Childress) Nursing schools sometimes add discussion of Ethics of Care or teach a specific nursing-centered “Code of Ethics” that includes an idealized ethos of service. (Fowler)

Continuous learning and improvement are an important mandate in the practice of medicine, as reflected in continuing medical education requirements set by each state medical licensing board. (Board Vitals) Whether a nurse, pharmacist, physician, or other professional, one's continued licensing and credentialing is dependent on providing evidence of ongoing education in one's field of practice, which may include education regarding important ethical topics. In this effort there are typically many organized educational sessions within hospitals, especially teaching hospitals, both for trainee clinicians and fully credentialed care providers. However, once again these opportunities are siloed largely by profession. At times various professions will come together to discuss a medical case as a means of process improvement and/or emotional debriefing, but often there are typically no formal opportunities for interprofessional and interdisciplinary ethics education in the hospital setting.

This thesis argues that mandated, formal education sessions that cut across these somewhat siloed professions may improve ethical care and teamwork in the hospital setting. Using the lens of feminist social epistemology's concepts of situated "knowers" and Standpoint Theory, I argue that each student or learner may aid in the furthering of another's ethics education. I will spend the bulk of this paper discussing both the ethical and practical arguments of my position as a theoretical foundation, and will conclude by describing the potential ways such formal education may be introduced into both undergraduate and post-graduate medical venues, as well as the possible limitations and pitfalls of such an approach.

An interdisciplinary, interprofessional approach to medical ethics education—both pre-professionally as well as in continuing medical education – will aid all those involved in medical care by instituting and fostering a culture of seeking out and learning from individuals outside of one's own profession. The term *interprofessional* in this discourse will refer to a learning group

or working group that consists of individuals of distinct professions and/or fields of study. (Nestor)

In the medical setting an interprofessional team includes various care providers beyond subspecialists within one type of care provider, such as a physician. An example is an interprofessional ethics committee that consists of nurses, physicians, chaplains, respiratory therapists, social workers, lawyers and administrators. *Interdisciplinary* refers to education that involves the differing healthcare specializations not only sharing knowledge, but also learning from one another and working together to form a *new understanding* or novel work plan that is both jointly created and executed. (Choi and Pak)

Practice informed by this interprofessional, interdisciplinary education may lead to a more nuanced and comprehensive approach to healthcare. With regard to particular patients, such an approach may elicit and more fully incorporate a patient's narrative and perspective, and may also consider multiple aspects of a patient's care. In this way a healthcare team would be able to deliver more ethical care and higher quality healthcare. This approach may also further facilitate transparency in medicine by bringing together all care team providers so that they are equally privy to the same ethical grounding and vocabulary, and share in learning the implications of medical advances. A related, important benefit would also be enhancement of team communication, as such an educational structure counters a long-held culture of hierarchical practice and rigid divisions of labor within medicine. Such hierarchy and division of labor often create barriers to communication, which can then undermine ethical care and exacerbate emotional and moral distress amongst care team members.

## 2.0 Situated Knowers and Standpoint Theory

The situated “knower” refers to an individual whose particular knowledge base is informed by his or her unique set of experiences granted by his or her specific social location. (Grasswick) Nancy Harstock explains that in Standpoint Theory the “knower” does not gain her/his epistemological significance from merely being. A “Standpoint” is more than a perspective or viewpoint. Rather, it is specific relational knowledge gained from active *engagement* in one’s function within one’s social location. This relational knowledge empowers the “knower” – classically a person in lower social/political standing - to be able to speak their truth in the face of power differentials. (Harstock)

These functions and social locations include not only social roles, geographic location, and actions vis-à-vis others, but also functioning within these locations *as* a person with various characteristics, such as age, economic status, educational background, influential life experiences, race, ethnicity, gender and sexual identity, and particular value commitments that help to shape a worldview. For a healthcare professional, her/his standpoint or relational knowledge also stems from a set of experiences that could and generally does include personal life, community engagement as a clinician, clinical work experience and education/schooling. Thus, the knowledge-base of most nurses would be shaped by the uniqueness of nursing school classes, and spending his or her day in carrying out the tasks of patient-care – cleaning the patient, administering medications, obtaining vital signs, and providing emotional care – as well as the features of home and social life that shape the standpoint of any person. A physician’s knowledge-base is alternatively informed not only by his or her unique home and social life, but also by medical school classes and the hospital workday that consists of seeing many patients for

somewhat brief periods of time: time spent in problem-solving medical issues, chart documentation, and medical billing.

In a strict sense, each situated “knower’s” standpoint is unique, as each has individual experiences engaging and functioning within his or her respective social locations. However, commonality may often exist across individual standpoints as certain aspects of social location are somewhat shared. Take a group of ICU nurses, for example: each individual nurse has a unique personal experience in the world, but all share some common demands and tasks in their professional roles in their daily cleaning of patients, medication administration and vital sign tracking. Because of this commonality, there is value in examining an issue from the standpoint of ICU nurses in general, as well as exploring the standpoints of individual ICU nurses.

This overlap in standpoints is similar to that of patients vis-à-vis their diseases or their experiences of the healthcare setting. Each individual who suffers from breast cancer is unique in her or his manifestation of symptoms and reaction to treatment, and yet there is enough commonality among patients that they may be grouped and studied as a cohort in medical research looking for improved diagnosis and treatment of the disease. Individual cancer patients each have their own standpoint of their illness, informed by their personal knowledge, family situation, emotional state, financial state and work situation. A 40-year old chemist who is a mother of two children and is the primary financial provider for her family has a patient standpoint informed by her personal knowledge of chemotherapy drugs, guilt over her inability to care for her children physically due to her ill health, worry over her family’s financial situation as she takes leave from work to undergo treatment. Her standpoint is very different than say a 20-year old single woman in college who is unemployed and without health insurance, and has just begun a new relationship. This woman’s experience would be informed by a fear of bankruptcy with medical bills,

derailment of her education, and potential affectation of a new romantic relationship. However, there still may be some overlap in each woman's standpoint in their shared concern over the financial burden of disease, for example, or their emotional experience in how they are informed of their diagnosis.

An important point in embracing standpoint theory is this recognition of a patient him/herself as a key situated "knower" in his/her own clinical care, as well as in the systemic design and execution of medical treatment and research. Returning to the example of oncology: women's experiences with cancer treatment have provided important critiques of the medical system and research, the dehumanization of patients, and related ethical concerns of healthcare. The play, *W;t*, for example draws on features common to many cancer patients' experiences of illness, medical treatment, and research, and offers a striking "patient perspective" on this experience. (Edson) This perspective reveals that although medical treatment may be well-intentioned and scientifically sound, it often fails to meet the needs and wishes of the patient at hand, especially a patient's emotional and psychological needs. This emotional truth of the play has widely been recognized by patients and medical care providers alike. (Friedrich)

A similar resonance has been noted in the story of Henrietta Lacks and her family – both Ms. Lacks's personal experience as a cancer patient and her family's experience discovering her role as an unwitting medical research subject – as recounted in *The Immortal Life of Henrietta Lacks*. (Skloot) Although best known as "HeLa", the source of invitro-replicating human cells, Henrietta Lacks was an African American woman of limited financial means and education in the 1950s. The book describes how Ms. Lacks was treated for cervical cancer by white male physicians who performed deeply invasive procedures and removed samples of her cervical cancer tissue to use for research – all without full informed consent. Importantly, aside from detailing the

appalling lack of communication given to Ms. Lacks in her medical care, this history describes the woman's personal experience dealing with both her medical symptoms and her invasive treatments. Thus Ms. Skloot conveys Ms. Lacks' standpoint as a marginalized poor, female, black patient as well as her standpoint as an ailing wife and mother in the 1950s.

Ms. Skloot also interestingly obtains the standpoints and histories of Ms. Lacks' husband and extended family regarding Ms. Lacks' role as an unwitting medical research subject. In this way the author demonstrates how the egregious exploitation of Ms. Lacks' bodily tissue has emotionally affected numerous people across geography and generations. (Skloot) The Henrietta Lacks story is but one of many that bolsters a standpoint shared amongst many African Americans that consists of a deep distrust of physicians and the institution of medicine in general.

Both the literary example of *W;t*'s protagonist and the historical account of Ms. Lacks highlight the power differential and hierarchy that has existed and continues to exist in degrees between a patient and their various medical care providers, most especially physicians. This hierarchy and differential in power often plays a part in the difficulty the healthcare system can have in meeting patients' needs and wishes. Embracing the patient as a situational "knower" with an important standpoint may break down that hierarchy and empower the patient to have a greater input and control over their own medical care.

The healthcare system-induced similarities in standpoints amongst members within a professional group suggest that there is value in gathering different professional groups' perspectives in individual patient care planning, as well as in the development of policy and practice guidelines. Differently situated knowers who share knowledge gleaned from their various standpoints may inform discussions of process-improvement and problem-solving. It would be difficult to truly enhance an asthma treatment pathway without input from nursing, respiratory

therapy, and pharmacy. Pharmacists bring not only specialized professional knowledge of the action and interaction of medications, but also situated knowledge of medications' availability and costs. Nursing and respiratory therapists similarly bring knowledge from their distinct professional education and situated knowledge of administration and tolerance of enteral and inhaled treatments based on their day-long and briefer interactions with a particular patient. Similarly, when improving the process of ethical discussions and enhancing the ethical content of a medical care policy, the inclusion of various specialized professional groups should also be sought.

In understanding, evaluating, and developing a plan in response to complex medical situations, attending to and basing decisions on a synthesis of these various standpoints may be essential to providing the necessary insights to make individual patient care decisions and to develop appropriate policies and global care practices. (Forrow, et.al.) Let us take the example of weighing the benefit vs. burden of a treatment proposed for a severely ill patient in the hospital. "Evidence based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research." (Sakett et al.). Physicians sometimes care for up to twenty patients in the course of a day and are usually the best versed in the statistics regarding possible outcomes, as well as potential complications of particular procedures or treatments, the systematic research relevant to an individual patient's situation. Although trained to varying degrees in skills useful for communication with patients, physicians are limited in the time they may spend speaking with a patient regarding care options. A nurse, conversely, is limited in the number of patients for which he cares during the day, and typically has less depth of understanding of the research relevant to a patient's condition. He spends much more time in the room with the patient between medication

administration, cleaning, changing linens, etc. This added time brings more opportunity for discussion and exploration of the patient's social situation and desires. A physical therapist might also be able to understand what physical debilitations accompany a disease process and its treatment, and the burdens of recovery both in the hospital and out. Lastly, a social worker brings depth of understanding of the financial and logistical impact a therapy course might have for the patient, as well as available social services and policy-imposed financial constraints. The social worker may also have pursued training in family systems theory or transpersonal theory, and this background and continuing interest may shape her observations of the patient's situation. These are but a few examples of the specialized knowledge bases and standpoints that may be of use to careful clinical evaluation.

Implementing the routine practice of seeking information and opinions shaped by various team members' standpoints may lead to increased understanding of the facilitators of and barriers to providing care that is both excellent and ethical. Examining issues and options from multiple standpoints may provide a more full, multifaceted, and nuanced understanding of problems and options. When considering the discharge plan for complex patients, using an interdisciplinary approach involving multiple standpoints may best identify potential barriers and burdens weighing against benefits of any proposed plan. Optimal rehabilitation and outpatient follow-up schedules may carry prohibitive financial, geographical, and social challenges for patients and their families – obstacles that the patients and their families may not yet recognize if they have never faced a need for rehabilitation. Recognizing *and subsequently communicating* these tradeoffs may help to prevent both potential conflict (between care providers or between the care team and patient) and unforeseen barriers to recovery/potential worsening of disease.

Consider a more specific exemplary scenario of a 69-year old man with depression, diabetes, and heart disease, who suffers a severe stroke and is on a ventilator. Prior to this hospitalization he had been living with his wife of forty years and his dog. The couple have no living children but are very active in their local community. The attending physician initially recommends tracheostomy, as the patient is not able to be weaned from the ventilator after two weeks of mechanical ventilation due to weak cough poor lung strength, and the team is hoping to send him to intensive rehabilitation. At this point the man is able to open his eyes and move his fingers when asked, but cannot communicate in any way. The man's wife, speaking on behalf of the patient, refuses the tracheostomy offered by the attending physician and instead requests compassionate extubation. The attending physician states that there is still a chance for a possible "meaningful recovery" and that the patient might regain movement in his limbs and the ability to interact with the world, although it is unclear to what degree. Such a scenario in many hospitals may spark a significant conflict between the physician and the wife of the patient. However, in an ideal scenario the physician involved has had the opportunity to learn with and from colleagues of various other specialties and professions. She might therefore hold an interdisciplinary discussion with nursing, social work, respiratory care, and chaplaincy. The team could discuss the narrative of the patient's life as well as his previously stated wishes.

The patient is noted by the chaplain to be a highly devout Jew who serves as a substitute Cantor at his synagogue. His wife has expressed multiple times to the chaplain that the patient does not fear death and hopes to have a natural passing. The chaplain happens to play golf with the patient's Rabbi, who volunteered independently to the chaplain that he was aware of the patient's current hospital admission and that the patient is a vibrant, active member of the

synagogue who often spoke of how much purpose in life he derives from his active service in the religious community, especially from singing in the synagogue.

The social worker mentions that the patient and his wife are retired and are currently living independently, solely on social security and have Medicare for insurance. The wife shared with the social worker that the couple has no living children, and that prior to his illness the patient had become deeply worried about their growing medical expenses and what they would do when they could no longer live independently. Although still quite independent herself, the wife is worried that with her advanced arthritis, she would be unable to help care for her husband at home unless she had continuous nursing assistance. The social worker herself is a 50-year old woman who recently lost her own father to cancer. Her father was also a fiercely independent man who loved golfing, and who had refused a second round of chemotherapy for his lymphoma due to his intolerance of the side effects and his inability to play golf while receiving chemotherapy. Although her father had refused the chemotherapy, he had left no advanced directive and so the social worker, the man's only child, served as his healthcare proxy once the man became critically ill with malignant pulmonary effusions in the hospital.

Lastly, the nurse and respiratory therapist both share that when they discussed with his wife the patient's joys, she stated that above all else he loved singing and sang "all day long." She stated multiple times that he would never want to live a life where he could not sing, and the respiratory therapist advises that even with the most advanced technology a tracheostomy would severely affect his singing ability. He might be able to speak with a tracheostomy, but not sing. The nurse in this discussion has a friend who is a professional singer, working as a studio vocalist and serving as a soloist in her church choir on the weekends. The singer frequently discusses with

the nurse that aside from it being her vocation, singing is the greatest joy in her life and provides her with her sense of identity and purpose.

In sharing knowledge gleaned from each of their standpoints, the team comes together to build a greater understanding of how the narrative of the patient's life supports the choice that his wife is making when she states that he would not wish to undergo tracheostomy. The team gains a better understanding of the patient's fierce independence and how he finds fulfillment in his life. This understanding, in conjunction with his unclear prognosis for neurological recovery, provides an ethical foundation for a mutually agreed-upon pivot to comfort measures alone. Through this discussion, the team is able to avoid further conflict and move forward in shared decision-making with the patient's wife.

What is described above is an ideal scenario in which a team can work together and use their multiple standpoints to develop a more epistemically accurate understanding of the patient's values, preferences, and circumstances to inform navigating the most ethical way forward in a situation that could at first glance seem ripe to cause conflict between the attending physician and the patient's surrogate. Rather than working in her hierarchical silo, the physician reaches out to learn from all other members of the hospital care team. In turn, the other care team professionals, who classically might feel "lesser" in their hierarchical standing and so more reticent to speak up, feel empowered to share their insights readily with the physician. This vignette illustrates how the relaxation in the classic culture of strict hospital hierarchy that may occur with interprofessional ethics education in standpoint theory may lead to a healthcare team that not only functions better but functions more ethically.

### **3.0 Interprofessional Ethics Education, Multiple Standpoints, and Improved Communication Skills**

In addition to Standpoint Theory's creating more comprehensive and nuanced funds of knowledge – both about individual patients and about ethically relevant issues within the hospital and healthcare more generally – than would otherwise be possible, using Standpoint Theory to structure interprofessional ethics education may create a forum that regularly draws together a diverse group of situated knowers for discussion. By formally conducting regular seminar sessions that encourage both active listening and nuanced interprofessional discussion, interprofessional ethics education may improve communication skills within the healthcare team. Members of different professions will be prompted to make their perspectives clear to their colleagues and to avoid using parochial jargon and communication shortcuts that are intelligible only to those similarly “in the know.” Development of these skills should serve to improve communication between healthcare providers and patients and families, as well, as it will enable those who talk with patients/families to “spell out” what they mean rather than revert to jargon and abbreviations. This may result in a care team member's developing a practice of not only more clearly discussing medical facts, but also of explaining one's standpoint to another professional (or even nonprofessional) and eliciting the perspectives of others in return. Demonstrating interest in others' perspectives is an important, ethically salient mark of recognition and respect. Thus, interprofessional ethics education forums may result in not only more accurate and comprehensive communication about particular patients that will help to develop the team's understanding of each patient's full scope of needs and goals, but also development of skills of communication that may

facilitate discussion with patients and their families. These are major epistemological and ethical goals of interprofessional ethics education.

A key aspect of this “team understanding” is the development of a *shared standpoint* that connects the various professionals involved in the medical team in a foundation of “team understanding.” This is most easily created when the team develops and employs a shared vocabulary and framework for ethical analysis. Interprofessional ethics education seeks to develop this shared vocabulary and framework, while at the same time encouraging professionals to use what they share to express and then analyze what they do not share: their knowledge gleaned from their different standpoints. This knowledge may not be only propositional, but may include knowledge of questions that need to be addressed.

Learning a common language and framework is important for successful teamwork and for achieving a successful outcome of any endeavor. No matter the setting, people work best together when they can easily and quickly understand one another, and so the language used becomes an important teamwork tool. So can a mutual understanding of the workflow to be undertaken. This is one reason that hospitals across the US have embraced the American Heart Association’s ACLS cardiac resuscitation algorithms and teaching for all of its care providers. To use in the case of a cardiac arrest (an event wherein a patient’s heart ceases to provide blood flow to the rest of the body). Nurses, physicians, respiratory therapists alike come together in the same training classes and learn together. Specifically, all education participants learn the same key medical terms, treatment algorithms, procedures (CPR, rescue breathing, etc.) and assigned duties in the highly structured cardiac arrest response. (American Heart Association, Inc.) In this way, regardless of their profession, all personnel who may respond to a cardiac arrest have learned the same language and methodology of resuscitation. When the event happens, people are able to quickly understand

one another and work in concert for the same understood goal. Similarly, by participating in ethics education together these various professionals will be able to more readily communicate well with each other and work in concert toward a shared ethical goal, such as identification of an appropriate surrogate decisionmaker, exploration of patient values, or planning for a shift from curative goals to comfort-focused care.

#### 4.0 From Standpoint Theory to Stakeholder Engagement

Involving professionals representing multiple professional bodies of knowledge and social standpoints, for example in analysis of a patient's case or an ethical problem, also helps to provide a more comprehensive view of the range of stakeholders actually involved in the case or problem. Stakeholder Engagement is a concept that is discussed at length in the realm of medical research, but also applies to clinical care and to clinical ethics education. In research there are arguments that those who have "skin in the game" regarding a research topic should be directly involved in the formation and execution of a research project. That is, if a scientist wishes to design a bra for breast cancer patients to wear after a single mastectomy then ideally the project should involve input from mastectomy patients, oncologists, breast surgeons, and bra manufacturers. Similarly, to develop an effective pre-exposure prophylaxis for HIV, researchers need not only to understand the immunology of HIV infection, but also to appreciate barriers to utilization that those most at risk for HIV face. This would include physical and geographic access to the treatment, affordability, social stigma, and convenience of administration. With informed knowledge regarding these points, researchers might be able to develop a prophylactic treatment that is actually utilized, and therefore reach the level of impact desired. Such knowledge can only be obtained by engaging those who are at high risk of HIV infection, including often overlooked populations such as women.

Ethicists argue that stakeholder engagement helps to fulfill an obligation to promote social justice. (Esmail, et.al.) The realm of research provides demonstration that stakeholder involvement may be instrumentally valuable to projects because it may "improve the relevance of the research question...and accelerate the adoption of evidence into practice." (Concannon, et.al.)

As James Lavery states, "...substantive community and stakeholder engagement (CSE) can improve performance, and even make or break the success, of some science programs by providing a means to navigating, and responding to, the complex social, economic, cultural, and political settings to which science programs are conducted." (Lavery)

Others argue that stakeholder engagement is intrinsically valuable as both an expression of respect to those involved in a particular case and an attempt to render justice owed. (Goering, et.al.) These epistemological goals are reached by pursuing "responsive justice," an attempt to achieve parity among stakeholders brought about not only by the well-known idea of equitable distribution of resources, but also the "recognition" of what underlying injustices are involved in a situation and the "responsibility" taken by those involved to redress those injustices.

The importance of *recognition* in the epistemology of *responsive justice* resides in the fact that in order to ensure morally right actions and equality in the treatment of both individuals and groups within society, it is necessary to recognize and validate the importance of each person or group's situatedness and needs. This sentiment is echoed in the argument that Iris Marion Young makes in *Justice and the Politics of Difference*, where she describes a transcendent "democratic cultural pluralism" that both recognizes and respects differences among varying groups and individuals as a demonstration of equality (Young). Through the more nuanced lens required to recognize and embrace differences, groups may also recognize their commonalities, such as the fact that all people overlap in their very humanity, as well as the overlapping interests that apparently different groups actually have. Such recognition may lead to an increased sense of community and caring among team members and between clinicians and their patients.

In our current healthcare education system, this recognition often requires experiential learning. For example, many physicians find an increased sense of commonality with their patients

once they themselves have been through a medical crisis. To approximate this experience, many physician book clubs and medical school classes read *When Breath Becomes Air* by Dr. Paul Kalanithi. (Kalanithi) In this memoir a successful but dying neurosurgeon details his journey as a patient with terminal cancer. Because he spends a good deal of the book also recounting his medical career and family life, it is easy for physician readers to identify with him, and through his subsequent patient experience, vicariously gain a sense of commonality with cancer patients.

Rendering justice in the medical arena not only involves recognizing the diversity amongst patients and addressing each individual's and group's specific needs, but also recognizing and respectfully addressing the issues among a medical care team. As previously described, the inherent hierarchy of hospital teams and staffing structures may promote conflict, disrespect, and even injustice on a professional level among team members. Stakeholder engagement in interdisciplinary ethics education may help solve or even prevent such issues by encouraging a culture that notices both the important differences and commonalities among team members, and validates the perspectives, ethical insights, and needs of each stakeholder involved. It would be critical for these sessions to demonstrate respect for the situated knowledge of every member from every profession. Thus, a greater sense of mutual respect and moral, if not professional, equality may be engendered throughout the team, and potentially empower all team members to speak up in the promotion of ethical patient care and mutually respectful interactions.

When coupled with the concept of "responsibility," stakeholder engagement's empowerment of interdisciplinary *recognition* has important and far-reaching implications in the improvement of overall patient care. An all too common effect of the growth in sub-specialization of medical care has been the disengagement of clinicians from a feeling of "ownership" of the problem and goal: healing or curing a patient. Many clinicians at times feel more like a "cog in

the wheel” of the medical machine, rather than like agents responsible for a patient’s well-being. By being engaged as valued stakeholders and situated knowers in the discussion of a patient’s ethical care, all involved clinical professionals may be prompted to recognize their active responsibility in ensuring just and ethical care of a patient.

Take, for illustration, the case of a 17-year-old boy being treated for a second relapse of lymphoma. In the past he has undergone multiple rounds of chemotherapy and a stem cell transplant. He comes to the oncology unit for his first round of induction chemotherapy since learning of his relapse. At rounds in the morning, the attending physician discusses with the resident physicians, bedside nurse, and pharmacologist the chemotherapy plan and notes that the risks of the medication, as well as the likelihood of benefit, were fully discussed with the family in clinic prior to admission. When the bedside nurse, who has only been working in this unit for two weeks, enters the room that afternoon to administer the first chemotherapy drug, the patient tells her he “does not want” to receive the medication but is “only giving it a try because that’s what his parents told him he has to do.” This scenario raises ethical issues of autonomy and consent in a mature minor.

A nurse in this scenario would rightfully question whether the medication should be administered at that moment to a patient stating he does not wish to have the drug. If the nurse in question does not feel himself to be an empowered stakeholder in the care of the patient, he might administer the chemotherapy agent without hesitation, perhaps feeling that his only obligation is to carry out the task ordered of him. On the other hand, if the nurse did not believe himself to be a respected member of the professional healthcare team whose voice was valued, he might instead act more stridently in response to the patient’s admission. The nurse might refuse to administer the chemotherapy, and directly accuse the parents of acting selfishly and not taking the boy’s

values and preferences into account. In that case, the nurse might be viewed as projecting his own feelings of disempowerment onto his patient in his understanding of the teen's stated motivations and wishes, especially without further probing for better understanding of the decision-making process behind chemotherapy.

In an ideal scenario the above nurse will see his role as a respected stakeholder in the patient's care and as a valued member of the healthcare team whose concerns are likely to be given a fair hearing. Rather than either automatically administering the medication, or stridently refusing to do so and entering into an adversarial interaction with the teen's parents, the nurse would endeavor to do two things: 1) engage with the patient, granting the boy the opportunity to share both his concerns about the therapy and his personal wishes, and 2) start a discussion among the care team and with the parents regarding the patient's concerns. In this way the care team might reach a more nuanced approach to potential therapy options prior to starting a medication that has significant burdens. Envisioning oneself as a responsible agent or stakeholder in health is not always natural or easy for individual professionals within the hierarchical medical system. Fostering this concept through education and training may help members of complex medical teams be able to fully embrace such a role and improve their ethical care.

## 5.0 Responsibility and the Ethics of Care

Joan Tronto defines *caring* as actions that are done in effort to maintain and improve ourselves, others and/or the physical world around us. She further identifies *caring* as occurring in four “phases”: *caring about*, *taking care of*, *caregiving*, and *care-receiving*. *Caring about* she defines as noticing or identifying when care is needed: recognizing that the woman sleeping on the park bench is a veteran who is homeless or noticing that the infant in a daycare is showing signs of infection. *Taking care of* has to do with assuming a position of responsibility for or ownership of the need identified and developing a plan to address it: designing a plan to find housing for the homeless woman (or more generally, identifying or organizing resources for veterans), or deciding the infant needs to be taken to the pediatrician. *Caregiving*, Tronto explains, is the corporeal or physical action of providing the planned solution to the identified need: arranging for the in-take of the homeless veteran into housing, providing services at that shelter, or conducting the physical examination of the child and prescribing appropriate medication.

Taking care and caregiving can take on different forms in various situations, depending on one’s relation to the recipient of care, one’s personal resources, and one’s social role and social location. For example, only trained medical professionals may provide healthcare to a person as described above (with the exception of true emergencies such as a cardiac arrest outside of a medical facility). Similarly, it may be wrong or even intrusive and disrespectful for a mere passerby to attempt to bundle a homeless woman off to a shelter or even provide information regarding nearby shelters. But it would be appropriate for a law enforcement officer to provide that information and to offer transport to a shelter. Both the passerby and the officer would be appropriate in making a financial contribution to the shelter, having recognized the need in their

community. It would also be ethically inappropriate for a daycare worker to administer medical care beyond her expertise, but would be an instance of taking care to inform the child's parents of the illness symptoms observed and suggest medical attention be sought.

Lastly, *care-receiving* is the phase of response to the intervention provided, as when the homeless veteran accepts shelter from the elements and does not demonstrate any feeling of diminishment by acknowledging her need for this care. While the child who begins to clear the infection may not be mature enough to embrace an ethically appropriate stance of care-receiving, the child's parents may be able to embrace the care-receiving in the child's stead. In accepting the help with identifying their child's need, and not becoming defensive about having failed to recognize the infection themselves, the parents would adopt an ethically appropriate stance of care-receiving (Tronto).

When discussing the normative values of an "Ethics of Care" Tronto states that to be "morally good" one must work to address the needs that surround oneself. This includes developing the important qualities of "attentiveness" and "responsibility." "Attentiveness" is the ability to notice when there is the need of care, and "responsibility" is the notion of taking ownership of that need or taking a vested interest in it. This is different from the concept of an obligation through which one's actions or participation are required by formal rules or laws. (Tronto)

By embracing standpoint theory and stakeholder engagement, interprofessional ethics education may instill and encourage the ethos of *attentiveness* and *responsibility* necessary to provide excellent and ethical care. By learning to seek out and appreciate others' standpoints—whether those of other professionals or of laypeople – clinicians may improve their own attentiveness to those around them and gain aids in recognizing a patient's many complex needs.

Both an ethics of care and the process of stakeholder engagement may help foster the sense of *responsibility* to act on behalf of the noticed need – either through planning (including development of policies and practices to address similar future cases) or direct *caregiving*. By endeavoring to elicit the standpoint of others, for example, a physician may learn from a chaplain that a patient feels isolated and forlorn by missing weekly mass and daily prayers at church while in the hospital. Taking responsibility for this need, the physician may ensure that the patient is wheeled to hospital mass every Sunday, and that chaplaincy is called regularly to pray with the patient at their bedside.

## 6.0 Interdisciplinary Ethics Education and Moral Distress

By utilizing standpoint theory and stakeholder engagement, interdisciplinary ethics education may not only develop a more nuanced approach to ethical problems but also help to prevent and diffuse moral conflict and prevent or address moral distress among care team members. First introduced by Andrew Jameton in the early 1980s, *moral distress* was originally defined as a situation in which a person makes a moral judgement and knows the ‘right thing to do’ in a given situation, but is constrained from doing so by institutional factors. (McCarthy and Gastmans) The classic example of such a situation would be the resident physician who has determined that the “right” thing to do for a dying, end-stage lung cancer patient in the ICU with worsening respiratory failure would be to place the patient on hospice care and avoid further aggressive interventions, but instead is ordered by her attending to endotracheal intubate the patient and put her on the operating room schedule for tracheostomy surgery. Importantly, as connoted by the idea of *distress*, this situation causes emotional and/or psychological pain or discomfort. This emotional toll is worrisome, as such stress has been linked with concerning issues such as burnout, detachment, and difficulty with retention of staff in the medical system. Nursing literature has even linked this phenomenon with the downstream effect of eroding the quality of patient care in clinical settings. (Rushton)

Over the last 20 plus years of discussing and exploring the concept of moral distress, many arguments have been made to broaden its scope. First, its reach was expanded to include not just the emotional toll felt at the time of a considered action (in our above example the time of intubation) but also the later emotional “fallout” of processing the situation (how the resident physician feels when reflecting upon the case a month after witnessing the patient’s prolonged

dying process, unable to speak, on a ventilator). Second, the constraining factors that give “moral distress” its *moral* component came to include not only external institutional factors (e.g., the attending physician who orders a particular care plan or inadequate resources to provide needed care) but also internal factors (e.g., one’s fear of speaking out that prevents one from acting on the patient’s behalf in a way that one feels is morally appropriate). (Campbell, et.al.) Elijah Weber in 2016 importantly pointed out that this emotional and psychiatric distress or stress is felt because of the individual’s perception of a given case. An individual’s moral judgement could be mistaken; and, an individual could misunderstand the perceived constraint from action. Whether mistaken or not, the individual experiences these same feelings and angst. (Weber) Developing an more accurate or more comprehensive view of the situation may resolve cases of moral distress founded on inaccurate understanding. Discussions that embrace the tenets of standpoint theory may help care providers to develop this more accurate and complete view.

A concept discussed alongside *moral distress* is the concept of *moral dilemma*. This is the negative emotional/psychological experience that occurs when two or more ethical principles, rules, or policies support divergent or opposing actions, and there is no clear guidance regarding how to reconcile the two. A third related concept is that of *moral conflict*: a situation in which ethical principles, rules, or policies oppose one another, but there *is* a conclusive hierarchy of importance among them so that resolution may be achieved. (Fourie) Unlike the strict definition of *moral distress*, the concepts of *moral dilemma* and *moral conflict* do not include the idea of the moral agent being externally constrained from action. The stress arises in both *moral dilemma* and *moral conflict* from either having no clear “right way” forward in the first case, or in the case of moral conflict, having to compromise one important ethical principle to move forward according to a another.

This thesis has argued that an advantage shared by both stakeholder engagement and standpoint theory is that all members of the medical team, regardless of their position within the hierarchical structures of healthcare (or within a particular healthcare institution), are recognized and respected as equal agents in a patient's healthcare. Ideally, this agency, this ability to act based on one's own decision about what to do, comes with a sense of responsibility to promote ethical care. Thus, when a member of the team feels that a choice is being made for a patient that is morally incorrect, that team member may be able to advocate for a change in course, or at least be able to spark a more comprehensive and thorough discussion regarding the care plan. Consider the earlier example of the resident physician whose patient is dying of lung cancer. Equipped with communication and epistemological skills by an interdisciplinary ethics education, the attending physician may hold a multidisciplinary team meeting to discuss the patient's prognosis and care options, and elicit input from resident staff, nursing, respiratory therapy, and physical therapy. During this discussion the resident physician may be similarly empowered to share her perspective that, given the terminal nature of the patient's disease, the right thing for the patient might be to offer hospice care as an option. Members of the care team would then have an opportunity to fully discuss the burdens and benefits of the treatment options. Subsequently, when the attending physician discusses treatment options with the patient's family, she may do so with a more comprehensive knowledge of these care options and may have a more thoughtful approach to making her care recommendations to the family.

The development of a more open interprofessional dialogue among care team members may also help to prevent team members from feeling moral distress or moral dilemma. Open dialogue may especially help prevent moral distress that can occur in response to an incorrect understanding of constraints on caregiving. One such scenario would be a nighttime bedside nurse

feeling distress over what she perceives to be a situation in which an 18-year-old man is dying of lymphoma but has not been told by his physician about the terminal nature of his disease. The nurse feels distress over this lack of transparency with her adult and autonomous patient, but might feel constrained by instructions passed on to her to not discuss prognosis with the patient. However, with full and open communication between the physician staff and nursing staff, the nurse would learn that prior to his admission the man requested not to hear any more information regarding his prognosis and instead requested that “only positive news” be told to him, with all other information being given to his parents who he requested continue to function as his surrogate decision-makers. Equipped with this information, the nurse may more comfortably take care of the young man knowing that she is following his wishes by withholding prognosis information. Providing care according to the patient’s values and express preferences is, at least in a case like this, a higher order ethical rule than one that supports ensuring the patient has material understanding of his condition.

Educating professionals within an interprofessional framework that encourages recognition of individuals’ standpoints may also improve team dynamics and minimize overall emotional distress that might stem from interpersonal conflict. Often the siloed and hierarchical setting of the hospital can create situations where the individual burdens and stresses of team members are not recognized by one another. A physician might not appreciate the severe emotional and physical toll a nurse goes through turning, cleaning, and medicating a large man with many painful-appearing wounds and lesions from third degree burns. Likewise, the nurse might not appreciate the pressure the physician feels under to try to provide the best medical outcome in every medical decision made, or how tired a physician is after being on service in the same ICU for 7 days. This lack of recognition may lead to a lack of empathy and mutual appreciation within the team itself,

which may intensify conflicts over patient care. In the more controlled and neutral setting of an interprofessional ethics seminar, these care team members may be empowered to share not only their insights regarding their patients but also salient features of their standpoints as members of the medical team. By opening this dialogue, various professionals in the team may learn more regarding the burdens and emotions experienced by each other and therefore become more connected and empathetic team-members. This could potentially lead a more ethical and collegial work environment for hospital employees.

## 7.0 Implementing Interprofessional, Interdisciplinary Ethics Education

The 20<sup>th</sup> and 21<sup>st</sup> centuries have seen the field of medical ethics, or bioethics, grow and evolve with the great changes in medical practice. Importantly, medical institutions and the professionals who work within medical settings have come to all embrace the importance of medical ethics and the importance of medical ethics education for clinicians and medicine-associated professionals (e.g., hospital lawyers, administrators, and patient advocates). Specifically, in the hospital setting this focus on ethics is demonstrated by the mandate, established by The Joint Commission that accredits hospitals, of an “ethics mechanism” in all hospitals. (Annas and Grodin) Often this mechanism has taken the form of an ethics committee that establishes ethics-related policies, reviews (or even conducts) ethics consultations, and provides or arranges for continuing ethics education within the institution. The importance of this formal development of ethics mechanisms, and often ethics clinical consultation mechanisms, is reflected in the work done by the American Society for Bioethics + Humanities (ASBH) in composing and educating hospitals regarding the core competencies of clinical ethics and ethics consultation. (American Society of Bioethics + Humanities)

Reflecting both the widespread embrace of ethics and the recognition of the value of an interdisciplinary and interprofessional approach to hospital process development, hospital ethics committees now generally are composed of representatives from a variety of healthcare professions. In addition to an interprofessional membership, many hospitals include non-medical community representatives on their ethics committees as stakeholders speaking for the patient population being served. (Courtwright and Jurchak; McGee, et.al.) Such diverse compositions of hospital ethics committees demonstrate a degree of appreciation of the value in seeking out

multiple standpoints and including various stakeholders in the development of healthcare ethics policies as well as in the oversight of the ethics of clinical care. To extend this practice beyond the confines of the ethics committee and into the ethics education of future and current hospital personnel, a focus should be placed on interprofessional ethics education. This approach is appropriate not only for continuing medical education, but also for graduate students and trainees prior to their professional licensing. The development of an interprofessional educational curriculum that employs – and perhaps explicitly teaches standpoint theory and stakeholder engagement in addition to other important ethical concepts – may improve not only the ethical care of patients in a hospital, but also the overall quality of medical practice and healthcare.

This thesis's discussion has presented ethical and practical arguments supporting an interdisciplinary, interprofessional approach to ethics education that embraces (and perhaps teaches) standpoint theory and stakeholder engagement as important cornerstones of its curriculum. What remains to explore is how in today's complex healthcare system such an education program might be established. There are two broad arenas where such an education may take place: professional schools (e.g.: medical schools, nursing schools, pharmacy schools, etc.) and in the hospital setting as post-graduate continuing professional education.

Within each of these two broad realms, educational requirements and structure are currently siloed by profession and then by local facility. In professional education, for example, accreditation for each profession is overseen and regulated by its own individual national governing body. The LCME (Liaison Committee on Medical Education) and COCA (Commission on Osteopathic College Accreditation) respectively oversee allopathic and osteopathic medical schools, the ACEN (Accreditation Commission for Education in Nursing) and CCNE (Commission on Collegiate Nursing Education) various nursing schools, the ACPE (Accreditation

Council for Pharmacy Education) pharmacy schools, the CSWE (Council on Social Work Education) schools of social work, and so on. These accreditation bodies are charged with providing a framework of required knowledge areas and skill sets that are imparted to students at each school. However, the specifics of any curriculum and method of teaching is left for each school or training program to determine. Many of these various professional schools exist in a shared geographical and administrative setting of an overarching university: for example, Columbia University administrates an allopathic medical school, graduate nursing school, graduate school of social work that all exist in New York City, NY. (Columbia University) However, there are also many medical schools that have no other associated professional programs or have them in a separate geographical location. Similarly, nursing education programs may be affiliated with undergraduate colleges which have other health professional programs, but may also be stand-alone programs.

In an ideal scenario, leadership from each individual professional program in a particular geographic area, for example, in the healthcare-focused city of Pittsburgh, Pennsylvania, would come together to design a common ethics curriculum that is taught to all of their students in an interprofessional setting. This would work best as a series of small group seminars where each group includes various professional students from pharmacy, dentistry, nursing, medicine, social work, and allied health professions. By structuring the “course” as a seminar, students may be encouraged to practice their communication skills and teamwork from day one, and the course may encourage the empowerment of each pre-professional student as an equally important voice in ethics discussion. To reinforce the concepts of standpoint theory and stakeholder engagement, these seminars would also ideally include instruction from teachers of each school’s faculty, and even perhaps some involvement of patients and community members.

The siloed and separated natures of professional education schools and programs provide a significant barrier to the development of such an inter-school seminar. Even in a geographical area dense in various professional schools, such as Pittsburgh, coordinating the availability of both students and faculty from the multiple schools would be a difficult challenge. In addition, having enough availability of space and faculty to host the number of small group sessions needed to educate the many interprofessional students would be another logistical difficulty. Such an endeavor would take an immense commitment of the varying institutions' leadership in time, resources, and funding for the educational program.

Professional schools and training programs that exist in relatively isolated locations would face the prohibitive barrier of access to students of other professional programs. One potential solution to this difficulty could be the utilization of technology for an online seminar where students can have a video-conference session. Although seemingly less effective than in-person discussion and teaching, video conferences could be more effective at reaching the goals of this interprofessional education approach than a traditional single-profession approach. Another solution may be to have an interprofessional faculty leading the ethics seminar, even if the student composition cannot be interprofessional. Alternatively, perhaps intermittent interprofessional seminars might be more attainable. In either case a concerted effort may be made to explicitly discuss different professional standpoints in order to learn what they add to the understanding of the ethics of healthcare.

In the post-graduate realm, there is perhaps better opportunity to bring together an interprofessional group of learners for continuing ethics education. Continued education is an essential component of nearly all healthcare professionals' maintenance of certification. Thus, there is a natural motivation for post-graduate participation in educational activities both as a

trainee and as permanent staff. The hospital setting in which all the professions work is a natural melding environment bringing together the professionals. Creating a seminar program becomes a matter of each professional department coordinating staff availability for participation and arranging for the education credits that motivate participation. Ideally, these seminars would at times bring together the various professionals who work within a particular unit – for example, the nurses, pharmacists, physicians, respiratory therapists and social workers who staff a medical ICU. By having a seminar focused on the interprofessional staff of a specific unit, attendees may not only gain ethics skills together but may also engage in teambuilding through their ethical discussions. At other times seminars might bring together professionals from across various practice settings and departments of the hospital. The inclusion of professionals from various areas of a hospital may reinforce the importance of every care team member’s standpoint as well as the member’s role as a stakeholder in the healthcare team.

Although for continuing ethics education physical proximity in the hospital-specific setting is not a barrier in the way it can be in the pre-graduate setting, barriers remain to be overcome for effective continuing education in the hospital setting. One important barrier is the differences in workflow and hospital presence on the part of the various professions. Attending physicians tend to follow a salaried pay structure where their time in or out of the hospital is not closely tracked for their compensation. In addition, they often have dedicated education or administration time built into their workweeks that allow for time spent away from patients. Physician trainees are also usually salaried, and have mandated educational time built into their work weeks when they are excused from duties of patient care. Other hospital staff members such as nurses and respiratory therapists, however, have a different workflow and compensation model. These professionals often have care duties so that during a designated clinical shift, they cannot leave

their patient duties for longer than mandated personal time (e.g.: lunch breaks). Thus, their educational time often is done on “days off” from the hospital, because they do not have designated administrative days. This would mean additional time commuting to the hospital beyond their proscribed workdays in order to participate in this education, possibly without compensation for their time at work. Thus, to make it more desirable for such staff to participate, the hospital administration would need to commit to compensating such employees for their education time.

Beyond the logistical barriers to this education strategy, an important potential impediment is the existing culture of separated leadership and hierarchy in the hospital. In most hospitals, each professional department has its own separate leadership structure. Even at the very pinnacle of hospital administration there is usually a separate Chief Medical Officer and Chief Nursing Officer for major hospitals. Thus, in order for this interprofessional ethics education to be successful it must first be embraced and supported by these distinct leaders. If this does not occur, any culture shift in ethical and practical approaches to healthcare that is developed within the confines of the education series might not be able to translate into actual practice.

The hoped-for culture shift within medical practice that standpoint theory and stakeholder engagement may bring to the hospital setting may also lead to some unintended problems in medical practice. The existing hierarchy within the hospital exists in part to organize healthcare so that “too many cooks in the kitchen”, so to speak, do not “ruin the soup” of a patient’s care. By having one attending physician ultimately serve as captain of the development and execution of a patient’s care plan, there is no confusion for the patient as to who is directing their care. This distinction is important for the patient to know, so they recognize the appropriate person with whom they can direct their questions and choices over their care plan. With the hierarchical model there is also less risk of various individual physicians, nurses, or allied health professionals

independently providing treatments that might counteract one another or interact dangerously. If this hierarchy were broken down completely without a clear organizational system being put in its place, then there would be an increased risk of unintentional medical errors and/or patient confusion.

Extreme change in culture and practice within the hospital is very unlikely. Not only do strong traditions support the existing structure, but there are also legal requirements that impose responsibility and liability exposure on the attending physician of record. The more likely outcome, as change within well-established institutions often occurs slowly, is that a more moderate culture shift may occur. This shift would involve healthcare team members respecting the existing hierarchy of the team structure, but also being empowered and encouraged to speak up and spark discussion regarding a patient's care or an ethical dilemma. It would also involve team members spending more time learning their patients' narratives and seeking patients' perspectives to better inform discussions of particular cases as well as of hospital policy.

## 8.0 Conclusion

Despite the logistical challenges it faces, an interdisciplinary approach to ethics education is both feasible and worth undertaking. Although not yet widely embraced, examples of interdisciplinary approaches to ethics education that combine two or more professions are described in medical literature. (Polczynski, et.al.; Cloonan, et.al.) Such examples demonstrate that interdisciplinary collaboration in education is possible. Even when it is overly burdensome to physically bring together students of varying professions, making standpoint theory and stakeholder engagement cornerstones of ethics curricula may impart the importance of an interdisciplinary approach to ethical discussion moving forward in actual practice. A nurse taught with such a curriculum even within the silo of nursing school, for example, may then seek out the standpoints of his interprofessional colleagues and patients once he is practicing as a licensed nurse on a hospital floor.

Continuing to move toward interprofessional education specifically in the realm of ethics with a shared, interdisciplinary-minded curriculum steeped in standpoint theory and stakeholder engagement may lead to significant improvements in the healthcare system's ability to provide high-quality ethical care to patients. Interdisciplinary ethics education also brings the potential of improving intra-team communication and dynamics by easing the rigidity of hierarchy within the hospital. Such improvements could lead to decreased levels of emotional and moral distress amongst care providers, which in turn could potentially improve rates of burnout and staff attrition.

## Bibliography

- American Heart Association, Inc. *Advanced Cardiac Life Support (ACLS)*. May 2019. 11 November 2019.
- American Society of Bioethics + Humanities. *Core Competencies for Health Care Ethics Consultation, 2nd Edition*. King of Prussia, PA: Rittenhouse Book Distributors, 2010.
- Annas, George and Michael Grodin. "Hospital Ethics Committees, Consultants, and Courts." *AMA Journal of Ethics* (2016): 554-559.
- Beauchamp, Tom L and James F Childress. *Principles of Biomedical Ethics*. New York, NY: Oxford University Press, 2009.
- Board Vitals. *Continuing Medical Education: CME State Requirements*. 17 December 2018. <<https://www.boardvitals.com/blog/cme-requirements-by-state/>>.
- Campbell, Stephen M, Connie M Ulrich and Christine Grady. "A Broader Understanding of Moral Distress." *The American Journal of Bioethics* (2016): 2-9.
- Choi, B C and A W Pak. "Multidisciplinarity, Interdisciplinarity, and Transdisciplinarity in Health Research, Services, Education and Policy: Definitions, Objectives and Evidence of Effectiveness." *Clinical Investigative Medicine* (2006): 351-64.
- Cloonan, Patricia A, F Daniel Davis and Caroline Bagley Burnette. "Interdisciplinary Education in Clinical Ethics: A Work in Progress." *Holistic Nursing Practice* (1999): 12-19.
- Columbia University. *Academics* 26 September 2019. <<https://www.columbia.edu/content/academics>>.
- Concannon, Thomas W., et al. "A Systematic Review of Stakeholder Engagement in Comparative Effectiveness and Patient-Centered Outcomes Research." *Journal of General Internal Medicine* (2014): 1692-1701.
- Courtwright, A and M Jurchak. "The Evolution of American Hospital Ethics Committees: A Systemic Review." *Journal of Clinical Ethics* (2016): 322-340.
- Edson, Margaret. *W;t: a play*. New York: Faber and Faber, 1999.

- Esmail, Laura, Emily Moore and Alison Rein. "Evaluating Patient and Stakeholder Engagement in Research: Moving from Theory to Practice." *Journal of Comparative Effectiveness Research* (2015): 133-145.
- Forrow, L, R M Arnold and L S Parker. "Preventative Ethics: Expanding the Horizons of Clinical Ethics." *Journal of Clinical Ethics* (1993): 287-294.
- Fourie, Carina. "Moral Distress and Moral Conflict in Clinical Ethics." *Bioethics* (2015): 91-97.
- Fowler, Marsha D. "Why the History of Nursing Ethics Matters." *Nursing Ethics* (2017): 292-304.
- Friedrich, M. J. "Wit: A Play Raises Issues of Emotional Need of Patients." *JAMA* (1999): 1611-1612.
- Goering, Sara, Suzanne Holland and Kelly Fryer-Edwards. "Transforming Genetic Research Practices with Marginalized Communities: A Case for Responsive Justice." *The Hastings Center Report* (Mar-Apr 2008): 43-53.
- Grasswick, Heidi. "'Feminist Social Epistemology'." *The Stanford Encyclopedia of Philosophy*. Ed. Edward N Zalta. Fall 2018.
- Harstock, Nancy C.M. "The Femenist Standpoint: Developing the Ground for a Specifically Feminist Historical Materialism," *The Feminist Standpoint Theory Reader: Intellectual and Political Controversies*. Ed. Sandra Harding. New York: Routledge, 2004.
- Kalanithi, Paul. *When Breath Becomes Air*. Random House, Inc., 2016.
- Lavery, James V. "Building an Evidence Base for Stakeholder Engagment: The private sector provides lessons and models." *Science* (2018): 554-556.
- McCarthy, Joan and Chris Gastmans. "Moral Distress: A review of the argument-based nursing ethics literature." *Nursing Ethics* (2015): 131-152.
- McGee, Glenn, et al. "A National Study of Ethics Committees." *The American Journal of Bioethics* (2001): 60-64.
- Nestor, Jane. "The Importance of Interprofessional Practice and Educaiton in the Era of Accountable Care." *North Carolina Medical Journal* (2016): 128-132.
- Polczynski, Angela M, Cathy L Rozmus and Nathan Carlin. "Beyond Silos: An Interprofessional, Campus-Wide Ethics Education Program." *Nursing Ethics* (2019): 2314-2324.
- Rushton, Cynda Hylton. "Defining and Addressing Moral Distress: Tools for Critical Care Nursing Leaders." *AACN Advanced Critical Care* (2006): 161-168.
- Skloot, Rebecca. *The Immortal Life of Henrietta Lacks*. New York: Random House, 2010.

Tronto, Joan C. *Moral Boundaries: A Political Argument for an Ethic of Care*. New York: Routledge, 1994.

Weber, Elijah. "Moral Distress, Workplace Health, and Intrinsic Harm." *Bioethics* (2016): 244-250.

Young, Iris Marion. *Justice and the Politics of Difference*. Princeton, NJ: Princeton University Press, 1990.