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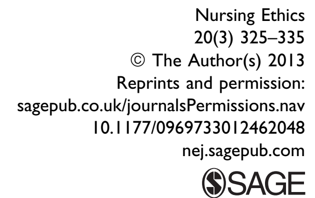

Interprofessional collaboration-in-practice: The contested place of ethics

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Abstract
The main question examined is: How do nurses and other healthcare professionals ensure ethical interprofessional collaboration-in-practice as an everyday practice actuality? Ethical interprofessional collaboration becomes especially relevant and necessary when interprofessional practice decisions are contested. To illustrate, two healthcare scenarios are analyzed through three ethics lenses. Biomedical ethics, relational ethics, and virtue ethics provide different ways of knowing how *to be* ethical and *to act* ethically as healthcare professionals. Biomedical ethics focuses on situated, reflective, and nonabsolute principled justification, all things considered; relational ethics on intersubjective, professional, and institutional relations; and virtue ethics on prephilosophical tradition and what it means to be good and to be human embedded in social and political community. Analysis suggests that interprofessional collaboration-in-practice may be more rhetoric than actuality. Key challenges of interprofessional collaboration-in-practice and specific conditions perpetuating dissension and conflict are outlined with specific education and policy recommendations included.

Keywords
Biomedical ethics, ethics, interprofessional collaboration, interprofessional practice, relational ethics, virtue ethics

Introduction

Collaborative practice and nursing in Canada have a long and intertwined history. A key ethical responsibility of professional nurses is that "nurses collaborate with other healthcare providers and other interested parties to maximize health benefits to persons receiving care and those with healthcare needs, recognizing and respecting the knowledge, skills and perspectives of all" (p. 10).[1] Nurses are positioned as moral agents who reflect on everyday practice and work with others "to create moral communities that enable the

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provision of safe, compassionate, competent and ethical care" (p. 5).[1] To qualify as professional, nurses are obligated *to be* collaborative, *to know* and *to practice* collaboration to maximize health benefits, and to create workplace environments that qualify as moral communities.

The professional imperative to collaborative practice resonates with a national call for new models of healthcare delivery.[2] One such model, collaborative patient-centered practice, is designed as integral to healthcare renewal, a way of healthcare professionals working together in practice and with patients, families, and communities actively involved.[3] Collaborative practice is conceptualized as

> the continuous interaction of two or more professionals or disciplines, organized into a common effort to solve or explore common issues, with the best possible participation of the patient. (p. 28)[4]

Collaborative practice is envisioned as "an interprofessional process of communication and decision-making that enables the separate and shared knowledge and skills of healthcare providers to synergistically influence the client/patient care provided" (p. 4).[5] *Interprofessional collaboration-in-practice* becomes a complex arena of different knowledges, practices, and value orientations, a place of differential relations of power[6] and moral complexities.[7] While designed to promote a synergistic working together whereby the knowledge and practice of each profession are respected and enabled, issues of turf protection and differences in value orientations surface yet often remain unexamined.[8,9] Curran[3] noted that "the professional system is based on separate silos of professional practice which acts as a barrier in different ways to collaborative practice" (p. 24). A critical question arises: How do nurses and other healthcare professionals ensure ethical interprofessional collaboration-in-practice as an everyday practice actuality?

We propose that understanding different ethical perspectives is critical to interprofessional collaboration-in-practice that "fosters respect for disciplinary contribution across all professions" (p. 28).[4] Ethics lenses become especially relevant and necessary when practice decisions are contested. We propose that if professionals practice from an understanding of different ethics lenses, the probability of successful interprofessional collaboration-in-practice would increase. New knowledges are brought to examining the "self," the "other," and the "institution." Reflexive contemplation of interactions with others and anticipation of the effects for health service delivery are consciously examined from the lens of ethical interprofessional collaboration-in-practice.

To illustrate this, two healthcare scenarios are presented and analyzed using three different ethics lenses: biomedical, relational, and virtue ethics. Biomedical ethics,[10–12] relational ethics,[13–15] and virtue ethics[16,17] provide different frameworks for knowing how *to be* ethical and *to act* ethically as healthcare professionals. These lenses, embedded with different emphases in current professional codes of ethics, provide direction for the examination of interprofessional practice.[1,18,19] The analysis focuses on the *how* of practice. Specifically, how do professionals interact with each other, how is a shared common effort organized to solve or explore issues, and how does each contribute. Recommendations for healthcare policy and interprofessional education are included. We begin with a brief overview of each ethics perspective.

Biomedical ethics: principlism

In 1979, the first edition of what was to become an authoritative text on ethics, *Principles of Biomedical Ethics*, was published.[20] With subsequent editions, a radical reconstruction occurred.[21,22] The "old" deontological principles established historically as the canons of biomedical ethics were embedded in a common morality framework reconceptualized as a universally shared product of human experience and history with particular moralities as subsets.[12] Significantly, previous accounts of the ethic of care were revised "as a form of virtue ethics" (p. vii). The task of the agent is to determine and justify, all things considered, actual obligations specific to the situation often in the face of competing values, principles, and norms. Four clusters of moral principles were defended and elaborated as general guidelines:

> (1) respect for autonomy (a norm of respecting and supporting autonomous decisions), (2) nonmaleficence (a norm of avoiding the causation of harm), (3) beneficence (a group of norms pertaining to relieving, lessening, or preventing harm and providing benefits and balancing benefits against risks and costs), and (4) justice (a group of norms for fairly distributing benefits, risks, and costs). (p. 13)

The proposed method, oriented to action, high moral conviction, and the lowest level of bias, was an integrated model of coherence or reflective equilibrium, a reflective testing and reconsidering of moral beliefs, principles, and theoretical postulates applicable to the case. In case analysis, principles become more specific to the case while case particulars are illuminated through the lens of moral principles, norms, and values. Analysis questions may include the following: Which moral principles are in question, by whom, and with what justification? Which rules and ideals come into play? Where are particular professional moralities and differences apparent and to what effects for ethical practice? The process of justification when united with common morality requires thoughtful considered judgments particular to moral life and to the case—individual, institutional, cultural, and situational. Arrival at a final lasting coherence is assumed a utopian ideal, and thus, ethical judgments become never-ending searches for best justifications, all things considered.

Relational ethics: ethic of care

Bergum[13] further developed Gadow's[23] work on relational narratives and the proposed relational ethic of care. Nursing practice narratives became a means for understanding care, moral choice, and ethical practice. Two key assumptions underpin relational ethics: (a) "The kind of knowledge needed for ethical care must be constructed in the relationship between the professionals and the patient, between the patients and their families, and even between theorists and practitioners" and (b) "truth is a matter of the context in which it is embedded" (p. 72). Three different forms of knowledge were proposed: descriptive, disengagement or abstraction, and inherent. Descriptive knowledge, subjective knowing, consists of the meanings of the lived experience. Disengagement or abstraction, objective knowing, is valued for its universality and generalizability most evident in theorizing, categorizing, and determining causality. Inherent knowledge, constructed knowing, emerges from the event of health and illness and involves social relations, intersubjective meanings, and the lived experience as a whole. The relational space, the location of enacting morality through practice-in-relation, holds all these forms of knowledge.

Four dimensions of relational ethics[24] were proposed: engagement as a relational process of emotional and meaningful connectedness; mutual respect as a means to new understandings and as essential for coexistence between people who are different but of equal worth and dignity; embodiment as lived reality of the body, the lived reality of who we are, and a recognition of the lived body as object; and environment as being the natural lifeworld, the critical elements or characteristics of each lived (healthcare) situation. Nurses' being-for-the-other becomes a site of ethical sensibility, of emergent nursing knowledge assumed as prereflective, preontological, and residing on a moral foundation through which nursing practice wisdom and sensitivity are fundamentally related to ethics.[15] In nursing practice, being-for-the-other involves openness to the vulnerability of the other, "the awakening of consciousness of another's suffering" (p. 230). Furthermore, in healthcare situations, engaging in the lived life while engaging in the lived body is the embodiment of care.

The four interrelated relational themes assist us in understanding ourselves as we engage with others. A practitioner asks, "How should I act?" and "What is the right thing to do both for oneself and for others?" (p. 485).[23] All relationships are assumed as moral, and quality relationships are viewed as mutually respectful reciprocal processes of reflective dialogue oriented to achieving shared goals, a process of intersubjectivity essential to ethical relations. What is ethically relevant is considered in the context of a trusting and often complex environment where a clear understanding of the other's circumstances is paramount.

Virtue ethics

MacIntyre[16] in *After Virtue* offered what was to become a provocative work reexamining modern-day morality. He proposed that instrumental rationality dominates the modern ethos with actions primarily informed by reasoned beliefs, none of which may be *right*. This modern-day reliance on instrumental reason obscures the significance of values and means to ends, privileging facts and outcomes over motives and character. He offers an alternative that relies on the "tradition of virtue" whereby "embodying the precepts of the natural law, would direct us towards the achievement of our common goods and educate us to become citizens who find their own good in and through the common good" (p. xi).[17] A virtue ethos is conceptualized as a social and political practice, a narrative of human life, and a moral tradition.

The notion of practice figures large for MacIntyre.[16] Practice becomes the means to virtue and virtue the means to the internal good of practice. Through an iterative cycle of pursuing the internal good of practice ("goods of excellence"), practitioners both emulate and cultivate virtue. Practitioners only exercise sound practical reasoning through orienting to the "pursuit of goods of excellence inherent to social practices" (p. 12).[25] This Aristotelian notion of practice rationality assumes that (a) to be human is to act rationally in society with others, (b) to act justly is to orient to the good, (c) reason and action are partially constitutive, and (d) the greatest good is the good life.

Practical reasoning offers healthcare professionals a more complex discernment distinguished from traditional objective and instrumental reasoning in orienting practitioners to good and just action, the internal good of healthcare practice, the specifics of the healthcare setting, and virtuous character. Practical reasoning requires practitioners to be aware and sensitive to deeply held morals, values, and beliefs of self and others. Engagement in practical reasoning is agent centered and action centered requiring practice judgment or practice wisdom that is situated in place and tradition; in relation to self, other, and society; and in the particulars of each situation. The practitioner considers not only "what should and must I *do*?" but also "what kind of person am I and should I *be*" in relation to others and in relation to the good of practice.[26] Virtue ethics is both an ethic of aspiration and an ethic of obligation, a way of being, and a means to the good of practice.

Interprofessional collaboration-in-practice: scenario 1

The interprofessional team has an established tradition whereby the Psychiatric Mental Health Nurse (PMHN) is responsible for initially interviewing the client, completing a thorough nursing assessment, and determining the problems and needs of the client. The information is then presented at a team meeting, and a team approach to treatment is determined. Two new physicians recently joined the team. In this scenario, the PMHN is prepared to present the nursing assessment and analysis to the team. When the nurse attempts to do so, the physicians indicate indirectly that they do not require the information. The nurse states that "it was obvious that they were not interested in the information collected by the nurses as the physicians did not refer to the assessment or nursing notes." This was further interpreted as nurses not being capable of completing accurate assessments and providing useful information, nor competent enough to assist in client diagnosis and treatment. The nurse felt insignificant, and the team approach became fragmented. In addition, the physicians would not attend team meetings on a regular basis, stressing how busy their schedules were. When one of the nurses approached one of the physicians to outline the nurses' concerns, the physician reacted with surprise and then reassured the nurse that the team approach was important and necessary. In the short term, team attendance at meetings improved with the intent to review and discuss difficult "cases"; however, this never materialized in practice.

Scenario 1 analysis: the lens of biomedical ethics

Using the reflective equilibrium approach, it is important to consider the particular individuals; institutional, cultural, and situational conditions; and relevant moral principles. In this scenario, established team

tradition is interrupted by the arrival of two new team members and by those new members changing an established team pattern of interaction and decision making. The new members do not follow the team approach tradition of sharing information. The new members' actions are interpreted as disinterest in the information offered by other professionals. Consequently, the PMHN feels insignificant, the nurses are positioned as incapable, and interprofessional practice becomes fragmented.

Two general principles come into play: (a) respect for, enactment of, and negotiation of professional autonomy and (b) the dual obligation of beneficence. Compromised professional autonomy emerges as a critical source of tension for the nurses and for interprofessional collaboration as a whole. For the nurses and implicitly for the collective, professional autonomy was diminished, perhaps even discounted and delegitimized. Where previously the nurses felt respected and contributed significantly to client care deliberations, current contributions by nurses were now interpreted as less valued. According to Beauchamp and Childress,[12] two conditions are considered essential for autonomy—independence (self-rule) and agency (capacity to act). In interprofessional practice, autonomous independence and agency are subject to professional, legal, institutional, and ethical constraints. However, at minimum, professionals are asked to understand each other's perspectives, responsibilities, and competencies. In interprofessional practice, professional autonomy becomes a negotiated principle whereby the views and rights of the other are to be respected as long "*as thoughts and actions do not seriously harm other persons*" (p. 64).[10] A lack of respect for professional autonomy in this scenario has deleterious effects for particular professionals as well as for interprofessional collaboration.

Interprofessional collaboration also implicates a dual obligation of beneficence, an obligation to act for the benefit of the recipients of care (the patient) and an obligation to act for the benefit of others. The question of paternalism is raised in that autonomous choice is limited through some form of interference, either overt or covert. Words may not coincide with actions and/or remarks may be interpreted as condescending or devaluing, and institutional procedures and policies may not adequately support interprofessional collaboration in decision making. An interprofessional tradition of shared decision making becomes undermined. Obligations of specific beneficence rest on team negotiation of professional roles, commitments, and attendant responsibilities with consideration for institutional policies and procedures as well as disciplinary codes of conduct and standards of practice.

Scenario 1 analysis: the lens of relational ethics

In this scenario, from the perspective of subjective knowledge, the PMHN felt devalued, patronized, and thwarted in attempts to engage in meaningful dialogue. The subjective meaning that emerged was that nurses were incapable of providing information worthy of the physicians' consideration. From an objective knowledge perspective, the arrival of two new physicians resulted in a significant change to the team structure and team dynamics. The PMHN–physician relation became conflicted, and the nurse experienced profound tension that the physician ignored. Meaningful interprofessional relations, nurtured through mutual respect and dialogue, were missing, and thus, the coconstruction of inherent knowledge perpetuated professional relations of perceived injustice and paternalism.

The nurse perceived that her knowledge and expertise were not valued. The psychiatrist appeared uncommitted and team collaboration deteriorated. Disengagement was perpetuated. Embodiment for the nurse resulted in moral distress, disempowerment, and anger. Critical environment elements included a lack of resources to support conflict resolution and promote interprofessional collaboration, marked differences in valuing team collaboration in treatment decisions, differences in scopes of practice, and differences in professional interpretations of the client situation and ethical accountabilities. In addition, institutional policies legitimizing hierarchical relations and physician authority in treatment decisions were evident.

Nortvedt's[15] being-for-the-other as the site of ethical sensibility is in question. Ethically, what is asked of us in being-for-the-other when the other is an interprofessional team?

Scenario 1 analysis: the lens of virtue ethics

From the perspective of virtue ethics, the questions of "What should and must I *do*?" and "What kind of practitioner should I *be*?" are relevant in that the nurse perceived injustice and desired change in interprofessional collaboration-in-practice but that change never materialized. As MacIntyre[16] suggested, the modern-day reliance on instrumental reason may obscure the significance of values, motives, and character and perhaps the *significance of differences* in values, motives, and character of interprofessional practitioners and the healthcare institution.

The analysis from a virtue ethics lens orients to good and just action, the internal good of practice (in this scenario, interprofessional healthcare practice), specifics of the healthcare practice traditions and setting, and virtuous character and motives of the agents (practitioners and social institutions). One tradition, previously valued but disrupted in scenario 1, was the active contribution of the PMHN to interprofessional and patient care deliberations. This interprofessional tradition was highly valued by the nurses and perceived as validating the significance of nurses' contributions and expertise as respected interprofessional and collaborative team players. On one hand, there was an assumption that the new physicians would practice within the established interprofessional collaboration tradition. However, the new physicians seemed to practice from a different tradition perhaps without the knowledge of how the team had previously collaborated in care. Disruption of the established interprofessional collaboration tradition resulted in perceived injustice and fragmentation of care. Interprofessional relations became fraught with tension, uncertainty, and misunderstanding.

Virtue ethics asks whether practitioners orient to the good of practice, doing good for the patient, doing good for others, and being a good and virtuous person–practitioner. This orientation to the good of practice was also disrupted, perhaps for some interprofessional practitioners more than others, but certainly for the good of interprofessional collaboration-in-practice. Practice wisdom comes from understanding the complexities of a situation and also from perceptual accuracy of lived experiences, of knowing how to respond and being informed by moral sensitivity to the features of the situation. Emotions, feelings, and the values tacit to feelings become points of access to clarify what is happening and what is the meaning of the experience. The nurse felt insignificant and devalued in her professional practice that was aimed at doing "good" for the patient and being "good" in relation to others. Dialogue was initiated with some resolution. Sensitivity to the moral features of this scenario and to interprofessional collaboration-in-practice as a moral community of practice was not recognized, and thus, the opportunity to clarify what was happening and the effects remained unexamined.

Interprofessional collaboration-in-practice: scenario 2

An older adult residing in the community is assessed by the psychiatrist as requiring admission to a hospital psychiatric unit. The psychiatrist requests direct admission to a subacute unit. Hospital policy is to directly admit to an admission unit, assess the person as medically and psychiatrically stable, and then transfer to the subacute unit. The PMHN manager of the subacute unit raises questions regarding (a) the unit mandate, (b) safety concerns for the person directly admitted as well as safety for clients already on the unit, and (c) insufficiency of unit resources for direct admission requirements. These concerns are shared by the director of programs who is a PMHN, PhD prepared. When the concerns are relayed to the psychiatrist, he angrily insists on admission to the subacute unit. He contacts his superior, and the elderly person is admitted directly to the subacute unit. Subsequently, the nurse manager receives an email reprimand, which is passed onto the

director of programs. The next day, a memo of reprimand from the medical director is sent to the nurse manager, the director of nursing, and the executive director of nursing stating that medicine is the only profession with the right to directly admit or reject an admission to hospital. The PMHNs felt unsupported by the director of nursing and the institution as there was no follow-up subsequent to the memo of reprimand. This eventually resulted in a senior PMHN resigning.

Scenario 2 analysis: the lens of biomedical ethics

The escalating intensity of disagreement, angst, and conflict involving a number of team professionals and institutional administrators is apparent throughout this scenario. The risk is that quality care provision could be compromised and that interprofessional collaboration-in-practice could be irrevocably harmed. A key consideration in this scenario is institutional policy and procedure. A breach in institutional policy and procedure occurs with the medical request for direct admission to a subacute unit. The psychiatrist mobilizes professional colleagues, positional authority, and institution policy and procedure to reprimand other team professionals and to reinstate medical authority regarding hospital admission policy. Given the information available in the scenario, there are discrepancies and inconsistencies in institutional policy and procedure that may in effect undermine interprofessional collaboration-in-practice and an interprofessional team approach to conflict resolution.

In healthcare situations, Beauchamp and Childress[12] suggest that "conflict arises because authority has not been properly delegated or accepted" (p. 102). In this scenario, both the nurses and the psychiatrists acted out of concern for the elderly person who required admission albeit professional autonomy was compromised for all. The escalation of conflict created conditions of oppression that limited the range of options and possibilities for collaborative team action. Issues of professional autonomy, legitimate authority, and professional collaboration remain unresolved with deferral to hospital admission policy. "Above all do no harm" was a concern for the nurses and psychiatrists in relation to the elderly person; however, for team relations, harm was felt by all parties. Negotiating a resolution is a cardinal sign of interprofessional team collaboration that did not occur. Furthermore, hospital policy and the actions of those in institutional authority positions reinstated medical authority. Conscientiousness and self-reflective judgment *as a team* regarding the detrimental effect of actions on other members and for interprofessional collaboration was absent. Justice was not served as the conflict escalated with retaliatory actions that silenced and marginalized particular team members. An institutional culture of "bullying" and misuse of positional power was perpetuated further undermining interprofessional team collaboration.

Scenario 2 analysis: the lens of relational ethics

From the nursing perspective, a severe injustice was perpetuated through unfair tactics that denigrated nurses. From the medical perspective, a severe injustice was perpetuated by refusing a required admission and denigrating the authority of medical personnel regarding hospital admission policy. Which different knowledges came into play and for which professionals? The nurses relied on subjective knowing. The meanings of the lived experience for the nurses primarily involved the conflicted relational space between nurses and psychiatrists. There was a sense of moral distress. Nurses felt reprimanded, accused of professional boundary violation, and coerced into admitting the older adult to the subacute unit, despite the nurses objectively knowing that direct admission to the subacute unit may be unsafe. The psychiatrists relied on objective knowledge, assessed the older adult symptoms as requiring hospital admission and acted accordingly. (Inter)Subjective relational knowledge seemed lacking. Although not articulated, the subjective experience from the psychiatrist's perspective was one of being usurped in regard to institutional and professional authority and autonomy. Obviously, different knowledges and understandings were at

play. A cycle of escalating conflict ensued resulting in a lingering sense of demoralization for the nurses and a continued breakdown in interprofessional dialogue, respect, and collaboration.

Disengagement and conflict dominated the interactions between professionals. Embodiment as experienced by the nurse was a moral, ethical, and professional source of distress. Embodiment for the physician was perhaps moral and professional outrage. Environmental characteristics including institutional culture and traditions, hospital and unit policies regarding medical authority and admission to hospital, lack of resources for conflict resolution, and different professional knowledges brought to understanding the client situation and the "other" all contributed prominently to this scenario.

Scenario 2 analysis: the lens of virtue ethics

In this scenario, patient care coordination and decision making by different professionals resulted in overt conflict between professionals embedded in specific institutional policy and procedure traditions. From the perspective of virtue ethics, this may be a situation where instrumental rationality became privileged over and above "a coherent form of socially established co-operative human activity through which goods internal to that form of activity are realized in the course of trying to achieve standards of excellence" (p. 175).[16] In other words, professionals with presumably the best of intentions acted in accordance with institutional policies and established traditions but to the detriment of interprofessional collaboration-in-practice and the achievement of practice standards of excellence. Understanding the "good" from an individual practitioner and an institutional reasoned perspective obscured the social and moral features of this scenario. Sound practical reasoning achieved through orienting to good and just action, to the internal good of interprofessional collaboration-in-practice, and to good and just institutional policies and procedures becomes open to question.

This scenario serves to underscore a basic argument put forth by MacIntyre.[16] He suggested that modern life and, in this scenario, modern-day professional practice, in relying on instrumental reasoning, privileges ends over means, obscuring what it means to live well in community with others and obscuring how to flourish as human beings in relation to others and in relation to the world. For MacIntyre, the tradition of virtues sustains and cultivates human flourishing, healthy social relations, and professional practices of excellence. Virtuousness asks that practitioners emulate excellence of character, and in doing so, justice, courage, and truthfulness are cultivated in self, in social practices, and in institutional policy and practice. Chinn and Kramer[27] suggest that one way to cultivate practice wisdom is through praxis, an iterative and collective form of reflection-in-action. For interprofessional collaboration-in-practice, reflection-in-action requires collective and collaborative engagement in discussion, critique, and action oriented to good and just change. This also includes exploring conflicting values and seeking alternative actions responsive to the common good.[12] Reflecting on deeply held values further evolves understanding of the internal good of collaborative practice and acknowledging the value and contribution of each while honoring and constructing a flourishing community of collaboration-in-practice.

Future practice and policy considerations

Ethical analysis suggests that nurses' professional mandate for collaborative practice may be more rhetoric than actuality. The analyses of the scenarios illuminate particular difficulties in negotiating interprofessional practice tensions including overt conflict that in effect "harmed" interprofessional collaboration-in-practice as a whole. Despite the mandate for collaborative patient-centered practice with calls for participatory effort and respected and enabled contributions on the part of all health professionals, the primary focus was the nurse and physician. Other professionals were sidelined, even discounted as actively contributing practitioners. Significantly, institutional policies and procedures perpetuated

traditional inequities, serving to reify professional hierarchies over alternative interprofessional collaborative practices. Each ethics lens offers a perspective of value, a shift in the focus of analysis, and a shift in emphasis. Each offers a relevant and valuable contribution to understanding and furthering interprofessional collaboration-in-practice as flourishing communities of practice excellence.

Several relevant considerations for health policy design and for education become apparent. First, health policy and education must consider the multiple complexities at play in contemporary healthcare situations. These include interactional (interpersonal relationships and trusting, respectful communication), organizational (the teamwork environment, structure and philosophy, team resources, administrative support, communication and coordination mechanisms), and systemic (social, cultural, educational, and professional) determinants.[28] In a qualitative multiple case study analysis of seven UK mental health teams, the authors conclude that "services need to step away from the rhetoric of teamwork and help establish the structures and processes necessary to provide safe, respectful team environments that enable communication, collaboration and co-ordination" (p. 415).[8] Care coordination was enhanced when team structures and policies were explicit and when team interactions were respectful; resentment tended to grow when there was a lack of acknowledgment of what other team members had to offer; the use of humor was valuable in establishing an inviting and inclusive climate but could also signal tension or annoyance; and open, safe, and reflective participation by each and all members required a safe and trusting environment. Additionally, in a qualitative study of 60 professionals' perceptions of collaborative practice, role understanding and effective communication were identified as *the* primary competencies with willingness to commit to interprofessional collaboration as a necessary first step.[29] In the *National Interprofessional Competency Framework*,[30] interprofessional conflict resolution as well as interprofessional communication, patient/client/family/community-centered care, role clarification, team functioning, and collaborative leadership are considered essential practice competencies. This well-researched framework is a relevant and comprehensive resource that could serve as a guide to interprofessional education and health policy design.

A second consideration for education and health policy design is the moral-relational as a valued perspective for understanding ethics in healthcare.[31–33] In each scenario, interprofessional differences resulted in discord, disagreement, and conflict—an encroachment of professional autonomy and conflict of fidelity, a relational space of tension and moral distress and a striving for the internal good of practice. Each ethics lens offers slightly different moral-relational considerations for healthcare work. This includes explicit valuing of social–relational practices; open, authentic, and reflexive dialogue; reflective and considered judgments; and collaboration as embedded in communities of diversity where ethical–moral character is cultivated and where the healthcare environment is a place of ethical habitability. Healthcare environments must be understood as moral communities of diversity rather than as simulated marketplaces for health professionals' moral agency to flourish and their vulnerability to moral distress diminish.[34] For education, administration, and policy to support interprofessional collaboration-in-practice in the face of a dominant corporate healthcare approach, strategic alliances with, for example, clinical bioethicists and professional associations might be a place to start in *collaboratively* reconceptualizing, in curricula and policies, healthcare environments and practices.

Finally, ethical analyses suggest that we reconsider from different lenses, what it means *to know*, *to be*, and *to act* as professionals, as healthcare team, as healthcare organization, and as inclusive communities of practice. Epistemologically, successful interprofessional collaboration-in-practice requires acknowledging and legitimizing multiple ways of knowing, displacing dominant perspectives to surface alternatives that traditionally may have operated as marginalized and subjugated.[35,36] Disciplinary knowledge and assumptions are opened to critically examine the interrelated complexities of human dynamics, professional practices, and organizational structures at work.[37] Ontologically, consideration is given to the cultivation of professional identity as a work in progress, a situated social and political becoming-self embodying multiple subjectivities including the intersubjective, the interprofessional, and even the transdisciplinary.[38]

Professional autonomy becomes autonomy-in-relation to communities of others. Healthcare decision making involves a discerning practice wisdom with "recognition that we are all human and so share human things, but that we are also different, too, and those differences are important" (p. 231).[39] This suggests that both health policy and education embrace a "mosaic of viewpoints" that "push interdisciplinary practice beyond its traditional boundaries" (p. 129)[9] to show how all can be legitimate partners including the patient/client and public. Key challenges include the following:

1. Critical examination of primary identification with one's particular discipline and commitment to interprofessional, even transdisciplinary lenses, subjectivities, and practices.[3,29,30,38]
2. Commitment to genuine and reflexive dialogue that fosters interprofessional collaboration informed by the importance of relationships, practices, and actions guided by a virtue ethos of caring, "an emotional commitment to, and deep willingness to act on behalf of persons with whom one has a significant relationship."[12,14–17]
3. "Courageously address[ing] any and all barriers to ethical practice" at organizational, interactional, and systemic levels (p. 36)[34]. This requires knowledge of how professional and institutional traditions, legal, and other environmental conditions structure (inter)professional practice to maintain inequalities and conflicts; how team structure and processes sustain and/or challenge the status quo; and how to recognize and work through the complexities of power differentials, human dynamics, and organizational structures at work.[34,37]
4. Valuing new forms of ethical leadership, generosity, and imagination for organizations and communities of collaborative practice to flourish; the letting go of traditional scripts and creatively rewriting the script to move from marginalized to full participants in practice communities of inclusion and diversity.[33–41]

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Conflict of interest

The authors declare that there is no conflict of interest.

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