Disciplinary Inequality, Collective Agency, and Interprofessional Collaboration in Health Care

by

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AUTHOR'S DECLARATION

I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

I understand that my thesis may be made electronically available to the public.

Abstract

In this thesis, I apply collective responsibility theory to the problem of health care inequality between physicians and nurses. This analysis is conducted in the context of physician-nurse interprofessional collaboration (IPC) – a teamwork-focused approach to health care which improves nurse job satisfaction, and the quality of patient care. Specifically, I suggest that portraying actions undertaken by an IPC team as being guided by both individual and collective intentions uncovers dynamics governing nurse marginalization that would not be present in an analysis of an aggregate of health professionals. Using this argument, I conclude that nurses are discouraged from engaging in decision-making about patient care formally, through organizational structure, and informally, through professional culture. Although hierarchy in the health care system seems to re-enforce these issues, a rational authority model of hierarchy can be understood to decentralize authority from physicians to nurses.

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Dedication

For Jenny, Lexis, and Stanley.

Table of Contents

Introduction

   This inquiry examines the inequality between physicians and nurses in the context of interprofessional collaborative teams, and recommends a diverse range of institutional changes to the health care system to resolve these inequalities. The motivation for this investigation arose from my reflection on how bioethical conceptions of a physician-patient relationship might exclude an examination of the non-physicians who play a role in patient care. This reflection led to some questions about the implications of conceptualizing patient care in a way that excludes non-physicians. Does such a conception of patient care discourage non-physician input that could potentially improve patient care? Is there potential for the structure of the health care system to be optimized such that patient care is improved by including more disciplinary perspectives?

   Further, I became increasingly interested in whether the exclusion of non-physicians from making decisions about patient care could de-value or marginalize these professions, creating inequalities. I noticed that these questions raised issues of group membership, authority and responsibility, and the accomplishment of a joint goal – factors rendering the issue highly applicable to collective responsibility theory. In this thesis, I attempt to apply collective agency as a theoretical framework to better understand disciplinary inequalities between physicians and nurses in the context of interprofessional collaboration (IPC).

   In Chapter One, I consider the inequalities that pervade nurse physician collaboration and the kinds of collaboration models that might resolve such inequalities. I then explain and defend the claim that group decision-making is made using collective agency in Chapter Two. In Chapter Three I apply this claim to the health care system, and I make some recommendations on changes to organizational policy and professional culture that will empower nurses to make more central decisions regarding patient health. These changes are reconciled with current hierarchy in health care in Chapter Four, where a rational authority model of hierarchy is introduced. I conclude that both formal policy changes as well as informal initiatives to change professional culture to render nurses more central to making decisions about

patient care in IPC teams are necessary to resolve physician-nurse inequalities. Though hierarchy seems

to be a barrier, under a rational authority model of hierarchy, it can be instrumental in accomplishing

these changes.

Chapter 1

Interprofessional Collaboration in Health Care: Benefits and Challenges

1.1 Introduction

In this chapter, the problem of disciplinary inequalities in interprofessional collaboration is explored. Nurse job dissatisfaction and its potential threat to the quality of patient care is expanded upon as a symptom of the inequalities between physicians and nurses. This is because; although there is evidence that interprofessional teamwork can improve job satisfaction among nurses, nurses display notoriously poor attendance and participation rates in interprofessional team building as well as exercises in collaborative care. This disengagement is attributed to the marginalization of nurses by physicians. Based on this analysis, transdisciplinary collaboration is proposed as a model of IPC teamwork that improves nurse job satisfaction and the quality of patient care while discouraging marginalization.

1.2 Problem, A Wasted Potential

1.2.1 The Evolved Role of Nurses – A New Potential for Better Patient Care

Traditionally, the role of the nurse was meant to carry out the instructions stipulated by expert physicians. This is especially apparent when nurses worked from home before formal training programs for nurses began in the 1870s (Jecker and Self, 60). Some historians extend the history of nursing through most of the nineteenth century, where nursing took place domestically within the family (Jecker and Self , 60). In such cases the wife of the household often assumed responsibility for the sick and called upon kin and community for advice (Jecker and Self, 60). Advice and assistance often came from female neighbours with previous experience of illness gained from caring for their own families (Jecker and Self, 60). Alternatively women who took on a nursing role sought consultation with physician experts who "made house calls or were visited by patients in offices... to offer expert advice or perform a specific medical

3

procedure" (Jecker and Self, 60). Over time the distinction between what could be accomplished by the domestic nurse and what required the consultation of a professional physician became more pronounced. In the situations where such consultation was needed the nurses' role was subservient – "physicians used their presumed expertise to direct the caring process, while nurses who lived with the patients carried out the actual tasks of ongoing care" (Jecker and Self, 60).

In the late nineteenth century a professional nursing identity arose from this domestic origin, "when nurses left the domestic front to care for patients in hospitals and during wartime" (Jecker and Self, 292). This was reflected in the curriculum of the first professional nursing schools which focused mainly on practical skills (Jecker and Self, 292). Included in nurses' skill sets were traditional domestic tasks "such as bed making, feeding and hygiene" (Jecker and Self, 292). Along with this practical domestic identity arose the gendered stereotype that the division of labour among nurses and physicians was based upon a caring versus curing function – nurses mainly prioritize care while physicians prioritize cure. As a traditionally female profession, nurses were expected to be skilled at caring activities "because these activities involve the intimacy and close personal affiliation that women… prefer" (Jecker and Self, 287). Meanwhile expectations of medicine emphasized scientific and technical achievement as impersonal activities that men gravitated towards (Jecker and Self, 287). This association of caring with women's work depreciated the status of nursing as "women's work is devalued and most often unpaid" (Jecker and Self, 292).

Yet this caring and domestic nurse identity has evolved significantly over time, as nurses take on more diverse roles. In fact some nurses now hold technical and scientific roles, allowing them to supplement physicians in their care for patients and accommodate more patients. Acute care nurse practitioners (ACNP) exemplify this, as they are specialized to provide primary and acute patient care. ACNPs are educated at the master's degree level and "arose out of the need to have an advanced level practitioner to meet the needs of acute and critically ill patients in the inpatient setting" (Ely et al, 2889).

4

This provided ACNPs with a high degree of specialization, differentiating them from nurse practitioners trained in family, adult, or gerontology (Ely et al, 2889). In their education, ACNPs are trained in "critical care skills, including chest tube insertion, arterial puncture, central line placement, endotracheal intubation, managing ventilator therapy, and hemodynamic monitoring among others" (Ely et al, 2889). This is supplemented with a general knowledge of "pharmacology, physiology, pathophysiology, and patient care management" (Ely et al, 2889). For this reason, within the nursing discipline, only ACNPs have been educated and trained to manage critically ill patients in ICU settings (Ely et al, 2889).

Physician assistants are another example of a nursing profession used to supplement the limited use of primary care physicians. Ely et al describes the role of the physician assistant as being "focused on conducting physical exams, diagnosing and treating illnesses, ordering and interpreting tests, counseling on preventive healthcare, and assisting in surgery" (2889). By working in conjunction with a physician supervisor while retaining authority in medical decision making, physician assistants "augment the capabilities of primary care physicians [by filling the] service gaps caused by physician maldistribution, and help control healthcare costs" (Ely et al, 2889). Physician assistant training has branched to be applicable to multiple facets of care, including primary care, specialty practice and critical care (Ely et al, 2889). This training has been supplemented with the use of post-graduate programs to allow specialization, "such as surgery and critical care medicine" (Ely et al, 2889).

1.2.2 Job Dissatisfaction and a Lack of Support

Yet a persisting problem in the healthcare system is a lack of support of professional nurses. Perhaps one of the most glaring symptoms of such a lack of support at the institutional level is inadequate nursing staff. Inadequate staffing is problematic insofar as it contributes to job dissatisfaction by causing chronic stress, overwork and overtime – cited as the top three health and safety concerns by 70% of nurses in an American survey (Corley et al, 383). As a current and growing issue, Corley et al claim that the shortage of nurses impedes their ability to care for patients (382).

The difficulties which result from staff shortages are exaggerated by a work environment ill-suited to empower nurses to overcome the shortages and provide quality care. Due to the rapid pace of their work, "nurses experience difficulties with thinking clearly, [preventing] the early recognition of patients' problems" (Corley et al, 383). Additionally nurses who wish to invest time into a patient's care have little bargaining power. Fearing reprisals from the institution's administration for incurring costs, nurses feel unable to advocate for their patients to stay longer in the intensive care unit (Corley et al, 383).

The negative effects of short-staffing among nurses is made worse by the fact that many nurses leave their positions, or the profession entirely, due to moral distress – a negative "response to a dis-equilibrating stimulus in the social environment" (Corley et al, 382). Corley et al define moral distress where "[professionals] are conscious of the morally appropriate action a situation requires but cannot carry out that action because of institutionalized obstacles" (382). These obstacles include a "lack of time, supervisory reluctance, an inhibiting medical power structure, institution policy, or legal constraints" (Corley et al, 382). In a study conducted in the 1990s, 15% of nurses report claimed to have left a previous position or their profession entirely due to moral distress (Corley et al, 382). These findings are revealed to be a longstanding issue, as they are supported in a more recent study conducted in 2012. In the study, some nurses described feelings of decreased morale and decreased job satisfaction and considered leaving their positions because of experiencing moral distress (Funk, 484).

Further, moral distress often impacts nurses with both short term and long term effects. In the short term, nurses experience initial distress; feeling frustration, anger and anxiety when they first face the institutional obstacles that bring about interpersonal value conflicts (Corely et al 382). They then experience reactive distress as a long term effect, when they are unable to act upon or resolve their initial distress (Corley et al, 382). Interestingly, the moral distress which contributes to short-staffing among nurses is in turn the most prevalent cause of moral distress. Of those surveyed, nurses attributed the highest moral distress frequency and intensity their perception of unsafe staffing (Corley et al, 387). After

all, inadequate staffing causes a complex interplay of organizational factors which inhibit patient care (Corley et al, 387). These include "decreased frequency and quality of communication and collaboration, decreased ability of nurses to know patients, increased turnover resulting in less experienced staff, and difficulty with prioritizing problems about immediate need" (Corley et al, 387).

1.2.3 Team-building, A Possible Solution

Thus it seems that the most effective way to improve patient care and alleviate moral distress is to find a way to recruit and retain more nursing staff. Ajeigbe et al found that a method of accomplishing this lies in building teamwork. In the face of shortages among health personnel, healthcare organizations are working to create environments favorable to recruiting and retaining staff through the efforts of managers and hospital administrators (Ajeigbe et al, 1). These efforts have been concentrated on promoting satisfied staff, as staff that were happier with their jobs and enjoyed their work "had less burnout, and had a greater tendency to stay on the job" (Ajeigbe et al, 1).

Ajeigbe et al suggest using training and exercises which build teamwork in order to achieve greater job satisfaction among staff. The use of teamwork is supported through studies which establish a relationship between building teamwork and improvements in staff cohesion and camaraderie (Ajeigbe et al, 1). In fact, many of the positive effects of team building are factors which limit the institutional barriers which cause moral distress. These include "quality of communication, quality of interactions, improved work environment, social networking, trust among staff, working towards common goals, job satisfaction, job enjoyment, reduced burnout, and improved longevity" (Ajeigbe et al,1). Measuring the effects of teamwork upon job satisfactions, Kovner et al. found that work-group cohesion, supervisor support, and organizational constraint were among factors that predict more than 40% of nurse job satisfaction. The other factors included work and family conflicts, variety of work, autonomy, distributive justice, and promotional opportunities (Ajeigbe et al, 2). Meanwhile Adams and Bond discovered that

"work-group cohesion among nurses was associated with 51% of the nurse job satisfaction and staff-patient ratio was associated with 41% of nurse job satisfaction" (Ajeigbe et al, 2).

Testing as to confirm that there was a positive relationship between interdisciplinary teamwork and improved job satisfaction, Ajeigbe et al compared an interventional group and a control group of physicians and nurses in northern and southern California. In the interventional group, staff had undergone formal physician-nurse teamwork training – which was kept up to date (Ajeigbe, 2). This means that "new staff members... were trained on teamwork process during their orientations [while] current staff receiv[ed] yearly refresher courses on the teamwork processes" (Ajeigbe et al, 2). In addition, teamwork was operationalized in their emergency departments (2). Meanwhile staff in the control group was not provided any teamwork training and teamwork was not operationalized in their emergency departments (Ajeigbe et al, 2).

Ajeigbe et al found that there was a significant difference in reported job satisfaction between the interventional group and the control group staff (4), thus claiming a positive relationship between teamwork and job satisfaction. Explaining this phenomenon, they claim that practicing teamwork may increase frequency and quality of interactions between staff (Ajeigbe et al, 5). This increased communication between staff from different disciplines may help each understand what is involved in the other's job, allowing them to work effectively together (Ajeigbe et al, 5).

At an organizational level, teamwork training might encourage "strategies applied to improve effective communication between team members" (Ajeigbe et al, 5). Additionally, team building can improve the team climate and work environment among staff. Such an environment can encourage and empower team members to solve problems, formulate and carry out plans, as well as manage their workload (Ajeigbe et al, 5). Where team building efforts are successful, Ajeigbe et al expect that teamwork may increase "the cohesiveness between the nurses and the physicians... [and] remove... hierarchical feelings of superiority between the nurses and the physicians" (5). For this reason,

professional nursing standards in Ontario, and Canada as a whole identify interprofessional collaboration as necessary for quality patient care – making interprofessional collaboration a common reality as part of many nurses' working environments.

1.3 Resolving Tension in Interprofessional Collaboration

1.3.1 Power Dynamics as an Underlying Problem

Yet, while team building may seem to be a straightforward solution to staffing shortages and moral distress among nurses, it meets a great deal of resistance from nurses. Resistance to efforts which, at the surface, should improve working conditions indicates that there is an additional cause of job dissatisfaction which is not resolved through team-building alone. The entrenched reluctance to participate in interprofessional collaboration (IPC) displayed by nurses was first evident in notoriously poor attendance – despite the fact that interprofessional rounds have been identified as ideal for collaborative planning (Beales et al, 333). Traditionally attributing nurses' absences to timetable conflicts, patient care burdens, and professional socialization; strategies implemented by health organizations "such as more sensitive scheduling and interprofessional education have failed to improve nurses' participation on interprofessional teams" (Beales et al, 333).

Rather than a mere logistical barrier, low attendance rates of nurses at IPC rounds may be caused by interdisciplinary tension. Despite the substantial evidence that nurses contribute to a highly supportive environment within their profession (Beales et al, 336), the sentiment of nurses in the collaborative context was one of guarded professional solidarity. In the study conducted by Beales et al on IPC, a nurse commented that "there's a siege mentality [where i]t's the RNs against everyone else: social workers, occupational therapists, physical therapists, the doctors" (336).

The adversarial sentiment towards other professions and group cohesiveness among nurses leads to protectionist practices that could undermine interprofessional collaboration. For instance, a nurse

9

manager reported a case where "a nurse had overheard a social worker criticizing nurses to her colleagues" (Beales et al, 336). In response, nurses elicited a collective refusal to participate in interprofessional outings with social workers, and other allied professionals – a behaviour which persisted for several years (Beales et al, 337). Thus the cause of disengagement of nurses from IPC exercises is a more complex, deeply entrenched issue which results from interdisciplinary tension.

A promising explanation of interdisciplinary tension and the problematic experiences between nurses and physicians is as a result of marginalization of nurses by physicians. This marginalization stems historically from a system of power dynamics where the physician maintains higher status and authority (Dainty et al, 3). Interviews with medical residents revealed these power dynamics, which "found that their perceptions toward nurses were consistent with nurses' experiences of being viewed in a mechanistic way" (Dainty et al, 3). In other words, nurses are devalued as a tool used to carry out physicians' orders instead of colleagues with professional expertise (Dainty et al, 3). This disconnection between nurses' perceptions of their significance to patient care and those of physicians creates widespread reluctance among nurses to collaborate with physicians, as "sizeable proportions of nurses are dissatisfied with their interprofessional relationships with doctors" (Dainty et al, 3). Hence organizational changes to improve nurse job satisfaction ought to extend beyond implementing IPC to include measures that deconstruct power dynamics and facilitate a positive interprofessional relationship between physicians and nurses.

1.3.2 Care Ethics – The Nurse's Approach to Patient Care

One approach to deconstructing physician-nurse power dynamics is in terms of addressing their differing traditional approaches to patient care (nurses focusing on patient care and physicians focusing on patient cure). In this analysis, the problematic power dynamic between physicians and nurses is an unwillingness of physicians to understand nursing approaches to patient care. Dainty et al report that "physician[s tend] to de-emphasize relational aspects of patient care in favour of 'case knowledge' which emphasizes medical diagnostic and treatment-of-disease approaches" (3). The relational knowledge employed by

nurses is based on care ethics, where the emphasis lies in the well-being of the relationship between the nurse and patient rather than the mere well-being of the patient. Explaining care ethics, Nel Noddings claims that "we do not start with the individual, adult moral agent. Right from the start, we are concerned with the caring relation – from the briefest encounters and long-term associations" (53).

According to Noddings, these caring relations must be understood in the context of the carer and cared-for, whose roles lie in establishing and maintaining their relation (53). Describing the role of the carer, one is attentive; "she or he listens, observes, and is receptive to the expressed needs of the cared for" (Noddings, 53). An important aspect of being a carer is use of empathy to understand illness. Noddings expresses this by claiming that the carer 'feels with' the cared-for upon understanding that they have an expressed need (53). This empathetic process of feeling with the cared-for incites a displacement in one's motivation. In other words, their energy "is directed (temporarily) away from her own projects and towards those of the cared-for" (Noddings, 53). Moreover the carer is compelled to respond to the cared for in order to maintain the caring relationship.

Meanwhile, a caring relationship also requires contribution from the cared for, where one "responds in a way that shows the caring has been received [and] recognized" (Noddings, 53). Noddings exemplifies this with "an infant [who] stops crying and smiles in response to his mother's caress... a student [who] energetically pursues a topic after the educator's encouragement... a patient [who] breathes a sigh of relief under the nurse's gentle touch... [and a] library user [who] works effectively with new technology under the librarian's direction" (53). To Noddings, such a response from the cared-for is necessary for a caring relation, regardless of how much effort the carer puts into the relation (53).

In a practical setting, care ethics lends to what is referred to as emotion work. Emotion work is the "inducement or suppression of feeling in order to sustain the outward countenance that produces in others the sense of being cared for in a convivial and safe place" (Beales et al, 334). One implication of nursing emotion work is complying with rules that promote the profession's ideological image of

kindness, and feminine nurturing (Beales et al, 334). In doing so, however, nurses must suppress irritation towards patients and physicians in order to promote patient comfort.

Meanwhile, emotion work also involves an altruistically motivated sense of the nurses' vocation, as well as subjective feelings about authentic health practice (Beales et al, 334). Thus, in addition to the investigative and scientific aspects of medicine, emotion work "places a premium on information concerning the patient's broader emotional context, as well as nurses' reflections on care (Beales et al, 334). In nursing rounds, information which pertains to emotion work includes the degree of familial support and behaviour relating to the patients emotional well-being – for instance "whether the patient paced anxiously at night" (Beales et al, 344).

1.3.3 Disciplinary Differences – Lack of Understanding

One motivator for nurses to avoid IPC is that physicians commonly neglect to incorporate core values of nursing practice into interprofessional care (Dainty et al, 3). This leads to reduced communication and, in some cases, conflict between physicians and nurses. For instance, information relevant to a care ethics approach to patient care is often perceived by physicians to be redundant (Beales et al, 338). Beales et al report that in several interviews, physicians criticized that information about care brought about by nurses contributed to inefficiency in interprofessional rounds (338). Commenting on this perceived inefficiency, a senior physician described information relevant to a care ethics approach as behaviour that ought to be conditioned out of nursing staff. He claims that

> "the more experienced nurses will get away from [care based
> information], and talk about what the main issues are…More junior
> people who have just graduated tend to speak about a lot of information
> that's not necessarily important to tell us first thing in the
> morning…things like 'the brother-in-law would like you to call
> him'…We try to train them out of that, with some varying success"
> (Beales et al, 338).

This perception of the redundancy of issues important to nurses results in nurses being marginalized in their day to day communications. This is exemplified in the issues that nurses encounter

paging physicians. One problem is a lack of consistency and timeliness in responding to pages from the nurses. A nurse interviewed by Dainty et al reported that her nursing colleagues would often become frustrated when physicians do not return pages, negatively implicating patient care. "We'll get pretty mad when [the page is] not returned and then we have to send a patient to the ICU as a result" (Dainty et al, 7). As a result of this neglect to return pages, nurses perceive physicians as less diligent or caring (Dainty et al, 7).

This devaluing of care ethics work important to nurses is reflected in formal policy revealed in the development of standardized reporting checklists for interprofessional meetings (Beales et al, 338). On one instance, a reporting checklist was criticized by nurses as being too "heavily focused on medical information, and failing to incorporate nursing's caring concerns" (338). Observing, that the softer things are not included in the checklist, one nurse reacted by claiming that missing this information misses a crucial element of patient care. "We're caring for human beings... [a]nd I think that if we're giving a report, we need to talk about the whole story, not just the factual stuff about the assessment treatment plan (Beales et al 338). By not having their values of patient care acknowledged interpersonally and formally through policy, nurses are more reluctant to collaborate with physicians.

Additionally, nurses are rendered more reluctant to participate in IPC due to physicians' unfavourable reactions to communication with nurses. Feeling that most communication with nurses is redundant in nature, physicians become frustrated when contacted for what they deem to be a barrier to completing their interprofessional rounds efficiently. One medical resident confessed that "when you're on call and you get paged for something silly, you just get mad" (Beales et al, 338). They exemplified their frustration with an instance where they were on call and "asked for a patient's blood sugar to be checked around 3 a.m. and only to be paged if it was [less than] 3" (Beales et al, 338). They confess that they reacted negatively when they were paged by the nurse to be informed that the patient's blood sugar was at 9.3, despite the resident's instruction to only by informed if it were below 3 (Beales et al, 338). "I

actually said [raises voice], 'you paged me for that?!' I reacted, and I probably shouldn't have" (Beales et al, 338).

In fact, these frustrations are quite common among physicians, rendering nurses more cautious in approaching them with vital information. One nurse attributes these reactions to particular physicians, claiming that "[the hospital unit] has some physicians who are mean and rude and no one wants to approach them", moreover they cause everyone to scatter when they approach (Dainty et al, 7). In particular, the nurses are adverse to physician outbursts, as "some nurses have had the physicians yell at them directly and so will not approach them again" (Dainty et al, 7). These outbursts are relatively common as "most nurses can give you an example of a time that they paged a physician and got yelled at for it" (Dainty et al, 7). Alternatively, nurses are anxious to interact with physicians who pressure them for the exact information they want. For example "one physician gets agitated if the nurse who paged him doesn't have answers to his questions when he asks them [and] some physicians will just hang up on them (Dainty et al, 7).

These frequent explosions of anger from physicians towards nurses, considered an acceptable part of physicians' professional conduct (Beales et al, 334), is particularly problematic in the context of emotion work. As an attempt to create an environment which reassures and comforts patients, the "nurse's ability to accept, neutralize or soothe physician anger expressions, and suppress her own... indicate[s] professional competency" (Beales et al, 334). Beales et al observe that, "in the operating room... nurses use a variety of communication strategies... to negotiate constraints on their role autonomy in relation to physicians" (334). Despite attempting to benefit patients by neutralizing physicians, nurses may allow behaviour that harms patients. For instance, surgical nurses were found to concentrate on appeasing surgeons "which included refraining from commenting on poor surgical practice even when it contravened hospital policy or jeopardized care" (Beales et al, 334).

14

1.4 Transdisciplinarity and IPC

1.4.1 Avoiding Reductionism in Health

Thus it would seem that using IPC to support nurses in assuming more substantial roles in the health care system seems viable, but involves some obstacles. These obstacles mainly concern navigating the power dynamics and disciplinary differences existing between physicians and nurses. Yet as it stands, this analysis of nurse support and job satisfaction neglects to address key questions – namely, why we ought to support nurses rather than supporting physicians in their care of patients. Further, assuming that nurses should receive support, why is interprofessional collaboration a significant way to improve nurse job satisfaction? In answering these questions I conduct an analysis which connects disciplinary boundaries and power dynamics between physicians and nurses, illustrating this using interdisciplinary, multidisciplinary and transdisciplinary models of collaboration.

The efficacy of supporting nurses rather than physicians seems to be a problem in a results focused analysis. Yet by reducing the problem to the results of patient health such an analysis employs reductionism, "the attempt to reduce a problem to its most basic parts" (Albrecht et al, 58). A reductionist analysis of patient care is problematic as it favors the roles of two groups of health care providers, while erasing roles of others who may, in fact, be instrumental in improving patient health.

Professionals focused on the scientific aspects of medicine, for example physicians and surgeons, are one group favored by such an analysis. For instance, Albrecht et al claim that, rather than understanding the social/relational aspects of the illness, "cardiologists reduce heart disease to the workings of arteries and valves or even further to changes at the cellular level in the walls of these arteries" (58). Another group favored by a reductionist analysis of patient health are professionals in highly specialized disciplines, whose unique knowledge renders them fully necessary to improving patient health. Albrecht et al correlate disciplinary specialization with increased power within both institutions and society as a whole. After all, to provide such specializations requires controlling

15

knowledge, and the development of professional bodies that enable the use of such knowledge (Albrecht et al, 58).

Prioritizing or assigning importance to these professionals is not problematic insofar as they address the key scientific and mechanistic aspects of patient illness. Still it risks limiting patient care where it fails to account for the complex nature of health and the unpredictable nature of health outcomes (Albrecht et al, 58). Albrecht et al illustrate the complexity of health with The World Health Organization's (WHO) definition of health as an integration of physical, mental and social wellbeing. Under this definition, in addition to the mechanisms of patient health, genetic, physiological, social, ecological, and political factors also act as determinants of patient health (Albrecht et al, 57). Meanwhile, Albrecht et al note that the WHO rejects a causal or results oriented model of patient care by claiming that health is "not merely the absence of disease or infirmity" (57). After all, "health problems can emerge that could not be predicted, or readily understood, using causal models" (Albrecht et al, 58).

Thus the effort to support nurses in undertaking more diverse roles in patient care is an effort to deviate from mechanistic strategies to facilitate the interpersonal-social aspects of patient care. The interpersonal-social aspects of patient health are significant to accommodating more patients and saving costs to the health care system, as they work to reduce patients' length of stay and readmission rates. Ely et al cite a study conducted on non-physician care in a hospital's department of surgery where ACNP care for neuroscience intensive care unit patients was found to be more effective than the control group (Ely et al, 2889). Patients who were managed by ACNPs had significantly shorter length of stay in the intensive care unit, lower rates of urinary tract infection and skin breakdown, and took less time to become mobile (Ely et al, 2889). These results allowed for patients to spend less time in the hospital, and allowed for the hospital to save approximately $2,467,328 in one year (Ely et al, 2889).

1.4.2 Diversity and Models of Collaboration

Facilitating diverse approaches to patient care necessitates collaboration that is inclusive to the professional perspectives of all disciplines. To explain this approach, I will introduce and make the distinction between multidisciplinary, interdisciplinary and transdisciplinary models of collaboration. These collaborative models will be illustrated in terms of a medical research project underwent by Stephen Kunitz, a physician and anthropologist. Kunitz's project investigated the forces and process which led to the drop of the indigenous population of South America from 20 million to 10 million people in the wake of colonization, between 1492 and the 1960s (Albrecht et al, 60).

Multidisciplinary collaboration occurs where multiple disciplines work to address a problem that is mutually understood, yet there are "hard disciplinary boundaries are placed around [each aspect of the] problem" (Albrecht et al, 59). In a multidisciplinary model of collaboration teamwork is limited or non-existent, and each discipline works independently on distinct elements of the problem (Albrecht et al, 59). In the first stage of his research, Kunitz illustrates multidisciplinarity in his research by supplementing his epidemiological research on the resistance to acute infectious diseases of indigenous groups with findings from history, geography, ecology, demography, nutrition, political economy and anthropology (Albrecht et al, 61). Using these multidisciplinary findings, Kunitz argues that isolation and mobility were the key processes affecting the adaptability of South American tribal groups to disease brought on by colonization. Yet this answer does not explain the degree of disease-mortality, warranting an interdisciplinary investigation.

Interdisciplinary collaboration contrasts with multidisciplinary collaboration insofar as the multiple disciplines mutually understand and work on the problem together (Albrecht et al, 59). Despite involving more teamwork, perspectives of the collaborative in-group are favored, meaning that the perspectives of disciplines not included in the team may be ignored (Albrecht et al, 59). Further, there are 'soft' disciplinary boundaries placed around various aspects of the problem, where each professional

17

addresses the interconnected aspects of the problem using their own theories and conceptual frameworks (Albrecht et al, 59).

In the second stage of his research, Kunitz exemplifies interdisciplinarity by examining a topic that interconnects the fields of immunology and social psychology "the effect of acute infectious diseases on [colonized] populations not previously exposed" (Albrechtet al, 61). Despite this interconnected topic the problem is addressed with unique explanations from each discipline, and Kunitz presents his findings as an ongoing conversation or debate. Immunologists explain high disease-related mortality rates of colonized populations with the notion that present victims have not been selected for resistance to epidemics affected their ancestors (Albrecht et al, 61). Meanwhile social psychologists argue that these morality rates can alternatively be explained with the dislocation, demoralization and social collapse that accompany colonization - exacerbating the effects of the epidemics (Albrecht et al, 61). While each factor is plausible as an explanation, this research does not explain the connection between these factors.

Yet this connection can be explored using transdiciplinary collaboration, where a problem is understood as "an open, dynamic system operating at multiple levels... [and including] all relevant disciplinary insights" (Albrecht et al, 59). Kunitz renders his analysis transdiciplinary by applying a political-economic analysis which connects the immunological and psycho-social explanations of the issue into a comprehensive answer. The chronically high disease-mortality rate of South American Indigenous populations is attributed to Spanish colonists exploiting the indigenous as a servile labor force (Albrecht et al, 62). This analysis validates the psycho-social explanation, as being part of the lowest social and political levels... has contributed to a pattern of high infant mortality and deaths from endemic infectious diseases" (Albrecht et al, 61-2). Yet it also reveals that indigenous populations have continued exposure to exotic diseases, invoking an immunological explanation. "Even today, activities such as exploration and mining, road building and ranching encouraged by the Brazilian government,

18

multinational corporations and the World Bank result in increased exposure to exotic diseases" (Albrecht et al, 62).

As a technique that is focused on the inclusion and integration of disciplinary perspectives, transdisciplinarity seems promising as a model of collaboration in IPC. After all, it is the model of collaboration most receptive to deviation from traditional mechanistic approaches to medicine. It is also the least reductionist – enabling one to consider a complex interplay of processes and explanations that would not be possible using multidisciplinary and interdisciplinary models of collaboration. In the following section, I will consider the application of these collaborative models in the health care system and the challenges that need to be overcome.

1.4.3 Transdisciplinarity in the Health Care System

As it stands, Ina May Gaskin and Al Yasha Ilhaam characterize most health care collaboration as either multidisciplinary or interdisciplinary, criticizing that these forms of collaboration perpetuate asymmetrical power-dynamics between health care professionals. In particular, multidisciplinary work is problematic because, despite the involvement of multiple disciplines in resolving the problem, decision-making is often left to one discipline (Gaskin and Ilhaam, 191). Applied to the health care context, this means that multidisciplinarity grants physicians a cognitive authority over patients and non-medical professionals.

Meanwhile, interdisciplinary health care collaboration commonly exists in IPC structures such as ethics committees (Gaskin and Ilhaam, 195). Interdisciplinarity seems like a solution to multidisciplinary collaboration by allowing for more information sharing and a closer coordination among professionals (Stokols, 67). Still, the participants remain anchored in their disciplinary approaches to the health (Stokols, 67) and, in this way; interdisciplinarity still reinforces hierarchical relationships (Gaskin and Ilhaam, 192). Thus, while physicians may not formally be allocated the final decision, non-medical

disciplines including public health, nursing, midwifery, childbirth educators, and women's health activists are still marginalized in bioethical discussion (Gaskin and Ilhaam, 195).

As an alternative, using transdisciplinarity allows health care professionals to work together in a way that develops a shared conceptual framework (Stokols, 67). This model of teamwork between physicians and nurses may be instrumental in improving a mutual understanding of each discipline's goals and expectations (Stokols, 64). Such an understanding might, in turn, improve the efficacy of collaboration, as health care professionals can "extend discipline-based concepts, theories, and methods to address a common research topic" (Stokols, 67). As demonstrated in the previous section, integrating a multiplicity of perspectives might better enable health professionals to discover truths about the more complex and convoluted realities of patient health (Albrecht et al, 57).

In addition, mutual understanding of disciplinary goals and expectations can improve the quality of collaboration itself. Stokols warns that without this disciplinary understanding, physicians and nurses react dysfunctionally to cross-disciplinary feedback and could undermine patient care. In particular, Stokols criticizes what he calls a 'hit and run' model of consultation between disciplines, claiming that "a psychologist cannot simply walk in off the street, tell other people what they are doing wrong, walk away, and expect them to change their behavior. Rather, one must work with people . . . to facilitate the change process" (64). Thus, through a mutual understanding of goals and expectations, transdisciplinary IPC is significant to improving patient health, thereby reducing nurse moral distress.

Still, in order to implement transdisciplinary IPC successfully, it needs to be contextualized in a theoretical framework of health care that establishes the relevance of individuals to overall goals of the health care system. Without this means of support, implementing transdisciplinary IPC may worsen teamwork by forcing professionals out of their disciplinary comfort zones. Stokols claims that collaborative work often invokes tensions and conflicts among participants' disciplinary world views, interpersonal approaches based on different professional cultures, and departmental affiliations (69).

20

Without a system that grounds the roles of marginalized professionals in the overall goals of the health care system, initiatives to foster respect toward diverse perspectives and commit to mutual learning are too demanding (Stokols, 68). This risks unintended outcomes of collaboration, as IPC might inspire interpersonal tensions, fragment the team into subgroups with exclusive or competitive agendas, and create discouragement among team-members by undermining their ability to achieve collaborative research goals (Stokols, 69).

Furthermore, this framework must be highly versatile to accommodate the use of transdisciplinarity in collaborations that vary widely in scale and scope. Stokols illustrates this point in the context of scientific collaborations, where he claims that "bridging multiple research centers and disciplinary perspectives may be more difficult to sustain than those based within a single organization that attempt to link fewer fields" (67). This is also apparent when applied to large geographic regions, which are more likely to face collaborative challenges than more local efforts comprising of members (Stokols, 67). This challenge requires a theory that facilitates transdisciplinary collaboration at the macro level of organizational policy, and at the micro level of informal group work. Moreover, this theory needs to be able to account for how "collaborative climates and dynamics occurring at one level or scale may influence... activities and experiences occurring at more micro or macro levels" (Stokols, 67).

To summarize, a transdisciplinary model of collaboration is highly significant to the issue of inequality between physicians and nurses. This is because it can be used to avoid reducing the issue to a results based analysis, instead acknowledging the multiplicity of factors that influence nurse job satisfaction and patient health. As illustrated by Kunitz's research, transdisciplinary collaboration is highly decentralized in hierarchical structure, and integrates the most disciplinary perspectives in order to solve a problem. These factors contrast with multidisciplinary collaboration, a model of collaboration that involves little or no teamwork among disciplines, or interdisciplinary collaboration, a model that involves sharing disciplinary perspectives, though it yields little insight into how these perspectives are related.

21

1.5 Summary

In this chapter, nurse job dissatisfaction is explored as a barrier to patient care. While the roles of nurses have evolved and diversified such that there is a potential for nurses to supplement physicians in caring for patients, moral distress acts as a barrier to recruiting and retaining nurse staff. Initiatives to improve interprofessional teamwork show promising results in improving nurse job satisfaction, yet power imbalances and disciplinary differences act as significant obstacles to this strategy. Understanding the relationship between power dynamics and the inclusion of multiple disciplinary perspectives reveals implementing a transdisciplinary model of IPC is necessary to improve the, not only nurse job satisfaction, but the quality of patient health. Yet such a model of collaboration requires contextualization in a theory that links the roles of individuals to group goals, and is versatile - applicable to macro and micro levels of collaboration.

I believe that collective responsibility theory can provide the framework needed in order to overcome the challenges faced in transdisciplinary collaboration. Specifically I will apply a collectivist account of collective responsibility, which ontologically separates both individual and collective agency. In the following section, I will explain this ontological separation between individual and collective agency as well as surrounding concepts attached to this theory. In section three, I will develop the benefits of collective responsibility theory insofar as it supports transdisciplinary collaboration. Albrecht et al state that "our aim as transdisciplinary thinkers is to create a metatheory which weaves this multiplicity of perspectives into a coherent whole whereby the differences in approach are complementary rather than contradictory" (57). My goal in the next two chapters will be to show that conceiving interprofessional collaborative groups in terms of a collective agency will give significance to a multiplicity of disciplinary perspectives.

Understanding the connection between collective agency and transdisciplinary collaboration will not only improve nurse staffing, job satisfaction, and patient care, but it will also contribute to current

research regarding the application of transdisciplinary collaboration models. Stokols observes the "surge of interest and investment in large-scale interdisciplinary research networks and centers, yet too little is known about the circumstances... facilitate [the] outcomes of these endeavors" (64). Grounding these organizations in collective responsibility theory might reveal group dynamics which yield effective transdisciplinary collaboration.

Chapter 2
Developing and Defending Collective Agency

2.1 Introduction

In the previous chapter, nurse job dissatisfaction is established as a barrier to patient care. This is described in terms of moral distress, a chronic and psychological harm arising when nurses are aware of what they believe to be the morally appropriate action patients require, but are unable to carry out that action. Yet this can also be attributed to disciplinary barriers existing between physicians and nurses, which encourage power disparities and limit the quality of patient health. Based on this analysis, the implementation of transdisciplinary collaboration is recommended to dissolve these disciplinary barriers.

My plan in the remaining three chapters is to determine the structural changes that need to occur in order to achieve transdisciplinarity in health care collaboration. To accomplish this I will attempt to understand the disciplinary barriers and power dynamics of health care in terms of collective responsibility theory. In this chapter, I will explain the theoretical background of collective responsibility theory and formulate a position on how membership to a collective affects decision-making. In particular, I will argue that collective agency is ontologically separate from the agency of individuals. From this discussion I reveal equality of intention as necessary for a collective agency, which I attempt to reconcile with hierarchy exhibited in an organizational collective. This leads to the conclusion that equality of shared purpose relies upon contributing to rather than merely participating in a collective intention.

2.2 Theoretical Background

2.2.1 Situating Collective Responsibility Theory

Collective responsibility theory arose in the mid-twentieth century, when philosophers recognized that attributing moral responsibility entails more than "specifying a set of capabilities in individuals" (Isaacs

16). They found that the nature of an individual's action, and its consequences, are altered in a morally significant way when responsibility is understood in terms of how these actions interact with the actions of others (Isaacs, 16). This manifests in some cases of complicity, where an act that seems morally wrong in an individualistic analysis is the best possible course of action in the context of a group. For instance, Goodin and Lepora take interest in cases where individuals undergo a bargaining process in a group: doing something genuinely wrong in order to do something genuinely right (7). Using collective responsibility theory, they balance moral agents' intention to do good with their causal responsibility, thus capturing "the plight of moral agents trying to do the best they can in a world full of bad" (Goodin and Lepora, 8).

Additionally the nature of individual actions, and their consequences, is altered when individuals who act together produce outcomes that could not be achieved without a combined effort (Isaacs, 16). Tracy Isaacs exemplifies this with fundraising efforts. She states that "every year, across Canada, thousands of people participate in the Terry Fox Run [, typically raising approximately 20 million dollars] for cancer research" (Isaacs, 55). Despite various levels of involvement in the event, Isaacs affirms that the collective achievement of raising $20 million cannot be attributed to any one individual (Isaacs, 55).

Analysing these scenarios on an individual basis, assigning moral praise and blame can be problematic. After, all "to the extent that no individual raises [$20 million for cancer research], no individual is fully responsible for it" (Isaacs, 55). Still an individual assessment of a participant's action, for example a contribution of $200, does not fully capture the moral magnitude of their contribution (Isaacs, 55). After all, without this contribution of $200, the collective act of raising $20 million for charity could not be achieved (Isaacs, 57). It is the goal of collective responsibility theorists to develop an account of how praise and blame ought to be allocated in situations where an action cannot be achieved without a combined effort.

2.2.2 The Scope of Collective Responsibility Theory: Different Types of Collectives

Analyses of collective responsibility theory apply to collectives that widely range in their degree of structure. From highly structured collective entities, such as corporations, to loosely structured groups, to joint efforts between two people, collectives exhibit a high degree of diversity requiring that collective responsibility theory be flexible and versatile (Isaacs, 24). Still collectives can be classified into to two main categories: organizations and goal oriented collectives. Organizations possess a high degree of formal structure, and are not necessarily characterized by the size of the collective. Although nations or large corporations are conventionally considered to be organizations, small departments of philosophy also possess complex structures such as a formal constitution, and well-defined administrative roles and responsibilities that qualify them as organizations (Isaacs, 24).

While organizations are principally defined by their structure, goal oriented collectives are primarily defined by the degree to which they coalesce around the "achievement of a particular joint goal" (Isaacs, 25). Further, in a goal oriented collective, the joint goal requires or is pursued through, collective action (Isaacs, 25). Despite not having any formal structure, these groups range in their size and degree of coordination. "Two people going for a walk together, three people painting a house together, a thousand people doing the wave at a sports event, or tens of thousands of people 'Running for the Cure' all constitute goal-oriented collectives" (Isaacs, 25).

Meanwhile, Isaacs argues that some groups, such as societies that perpetuate wrongful social practices, require a collective solution insofar as they create outcomes that are not possible through any one individual action. Still she is reluctant to call these groups collectives, as they do not possess either of the characteristics defining an organization or goal-oriented collective. After all, despite the fact that the perpetuation of social wrongs is morally significant, there is no joint goal through which a group comes together in solidarity, or formal structures and processes guiding group decision-making (Isaacs, 25).

These groups are instead classified as aggregates: "collections of people that are grouped together because they share some common characteristic" (Isaacs, 26).

2.2.3 Collective Responsibility and Collective Agency

A significant area of research in the field of collective responsibility theory is the question of whether collective entities can be considered moral agents. This question is significant in applied ethics since, insofar as collective entities are considered moral agents, they can be held responsible for moral accomplishments or wrongdoings. Views on the existence of collective agency are contentious, as some philosophers identify as individualists while others as collectivists.

Although they believe collective membership changes the moral nature of the individuals actions, individualists claim that agency and thus moral responsibility can only apply to individual human agents (Isaacs, 23). They therefore explain collective action by reducing claims about collective agency and responsibility to claims about the agency and responsibility of individuals (Isaacs, 23). In contrast, collectivists are more holistic in their understanding of collective action, "arguing that claims about collective agency and responsibility do not reduce to claims about the agency and responsibility of individuals" (Isaacs, 23).

Yet collectivists' claims about agency and responsibility vary in strength, from the view that only some collective entities can qualify as moral agents to the view that all collectives qualify. The most common attributions of collective agency are to highly structured collectives, which have strong concepts of identity that are easier to dissociate from any particular cohort of members (Isaacs, 24). As a result, even using a weak interpretation of collectivism, "organizations, are the most obvious and least contestable candidates for moral agency" (Isaacs, 24). My plan is to develop collective moral agency as a framework that is highly sensitive towards power dynamics, and thus valuable to achieving transdisciplinary collaboration. To this end, in the following section, I will expand further on and defend the view that both organizations and goal oriented collectives possess collective agencies.

2.3 The Case for Collective Agency

2.3.1 Individual and Collective Intentions

The irreducibility of collective agency to individual agency is quite a strong claim, as it makes an ontological distinction between collective agency and individual agency (Isaacs, 24). Isaacs explains this ontological distinction with the argument that collective agency encompasses factors which could not bet taken into account by characterizing the group as an aggregate of individual agencies. This includes "the relations between individuals' intentions and the way individuals understand themselves in relation to others as members of a group" (Isaacs, 36). Such considerations are significant as they represent a new dimension to individual decision-making about group membership, and therefore have the potential to affect the allocation of responsibility.

One reason these factors cannot be captured with an analysis of individual agency is that they operate outside the degree of control we have over our intentions. Isaacs expands on this point by modifying Raimo Tuomela's conception of 'we' intentions, an intention encompassing multiple agents and is based on a group reason to act. Tuomela claims that 'we' intentions are necessarily collective, since construing them as individual intention loses aspects of the intention that characterize it as a joint effort. Isaacs exemplifies Tuomela's 'we' intention with a person's intention to make dinner together with another person (40). Although one can make dinner alone, one cannot make dinner together with another person individually.

The significance of 'we' intentions is that it "captures the intuition that what we intend must in some sense be under our control" (Isaacs, 39). Using notions of control as a basis for his conception of collectivity, Tuomela limits individual intentions to what is possible to achieve on one's own. An implication of this limitation is that individual intentions cannot encompass an entire collective act (Isaacs, 39) or even alter the nature of a collective action. Isaacs illustrates this point with the example of a goal-oriented collective doing the wave in a stadium. She states, "if there is a strong wave going around

the stands and I decide to sit it out when it comes to my section because I am playing on my smart phone, there is no good argument for establishing that it is a different wave from the one it would have been if I had participated" (Isaacs, 35). Therefore, at most, individuals can intend their particular contributions to collective actions (Isaacs, 39).

Though Isaacs agrees with Tuomela's reasoning that an individual's intention can only be contributory, she invokes Christopher Kutz in order to argue that collective 'we' intentions require more than the assumption that a joint action requires the contributions of others. 'We' intentions also require being asserted by a collective, as "individuals can[not] intend matters that are partly left up to other people" (Isaacs, 40). Kutz illustrates this point by claiming that, as a participant in a group action, one does not always deliberate about one's actions from a perspective that suggests that what the group does is up to him or her only (Kutz, 21). After all, doing so would put the agent in an executive position, which sometimes yields an inaccurate description of the inner-workings of the collective. Portraying collective intentions as executive individual intentions about the group is especially inappropriate in cases where participants contribute, but have "no views, let alone intentions, concerning what the group as a whole should do" (Kutz, 21).

Instead collective actions are intended by the collective, thus not implying that any one individual control has over the intentions of others. The example where 'I intend that we make dinner' seems like a 'we' intention, as it implies that the act must be completed as a joint action. Yet it remains as an individual participatory act. Meanwhile, 'we intend to make dinner together' characterizes a collective intention – an intention which accurately captures the characteristics of a joint action without implying executive control over the intentions of others. Attributing agency to collectives allows one to characterize intent in this way, as it renders collectives capable of a collective intent. As Isaacs states "collectives exhibit agency because they are capable of intentional action" (53). Individualists would resist this attribution by claiming that, with the right amount of work, collective intentions can be reduced

to the different degrees of intentionality exhibited by the collective's individual members. In the following subsection, I will explain how such a reduction is not possible.

2.3.2 How is Collective Intention Irreducible?

In part, the reason why collective intentions cannot be reduced to individual intentions is because there are factors that exist in the formation of collective intentions which cannot be understood in terms of an aggregate of individuals. Kutz argues that aggregates cannot account for the subconscious elements and the reflective form of collective intention. Hence these factors are not replicable when attempting to insert them as part of a description of an individual contribution to a collective action.

Kutz observes that some types of collective actions are less demanding of participants, and require only "a general sense one is acting concurrently with others... [and] adherence to conventions that minimize mutual interference" (4). A defining characteristic of operating on the collective intention of convention and a sense of acting with others is that it does not require a conscious thought about doing so. Yet it manifests itself in one's deliberation and action (Kutz, 10). The reason that subconscious collective intent is significant is that the recognition of acting in concurrence with others cannot be part of an individual contribution. In fact, one does not consider the individual contributions that lead to the collective action – the main focus remains on the collective end goal.

Kutz exemplifies this with wearing a dark suit in order to participate in a company, Citibank's, corporate culture. Kutz states that "wearing dark suits with the intention of being a part of that culture... constitutes my willing participation in Citibank's corporate culture" (11). Yet acceptance as part of this corporate culture does not require a conscious thought about putting on the blue suit. It simply "must at least be true that my putting on a dark suit is counterfactually sensitive to my acceptance of the norms that structure life in that organization: if I worked at a web start-up, I'd wear jeans and a tee shirt instead" (Kutz, 11).

What Kutz is attempting to illustrate is that intentions like these are easier to understand as collective intentions. At Citibank, part of the group intention is to maintain the corporate culture of wearing a dark suit. Portraying Citibank as an aggregate of individual intentions loses the meaning of the intent to wear a dark suit, as participating in a group culture is a subconscious dimension of any individual's decision on how to dress. Kutz explains this subconscious aspect of collective intention with an analogy of opening a door. He claims that the elements of collective intention that factor into individual deliberation are not construed in terms of the singular contributions. Instead, they are similar to how one does not usually think, as they pull on a door knob, that they are doing something that will result in a door opening (Kutz, 12). By portraying the intent to wear a dark suit as a collective intention, however, adherence to corporate culture makes sense in the context of the overarching group dynamics.

Yet Kutz recognizes that certain types of collective activity are demanding on behalf of participants, and requires conscious reflective deliberation about the collective intention. Two particular kinds of collective reflective deliberation are mutual interdependence and sensitivity (Kutz, 3). He defines these as the "close monitoring of one another's behavior, as well as highly determinate expectations of each other's plans" (Kutz, 3). Despite these being definitive conscious thought on behalf of individuals, Kutz describes these elements as additional material to individual deliberation about one's contributions to a collective. This is because it is only in a collective context where decision-making must be consistent with expectations about one another's preferences in an attempt to have these expectations converge (Kutz, 9). In other words, some situations require that members of a collective ought to reconcile their individual contributions with their expectation of the other members' preferences, as well as their partner's expectations of their preferences. Deliberating collective action in terms of these actions require the further conception of the others as being committed to joint resolution of the problem (Kutz, 9).

2.3.3 Participatory Intent – Individual and Collective Dimensions

As a result of the irreducibility of collective intent into individual intention, Kutz claims that one's intention as part of a collective act has both individual and collective components. This he labels as a participatory intention, "an intention to do my part of a collective act, where my part is defined as the task I ought to perform if we are to be successful in realizing a shared goal" (Kutz, 10). In one sense, this participatory intention is highly individualistic, referring to one's contribution to a collective act. Yet in another sense one has the conception of one's self as part of the collective action together with the other members of the collective – occasionally requiring mutual interdependence and sensitivity.

Thus a participatory intention manifests from both individual and collective motivations to deliberate. The individual motivation to deliberate is one's role in the collective action - which can only be understood in terms of individual contributions (Kutz, 10). Meanwhile, the collective motivation to deliberate comes from the purpose of the act. After all, a collective end "is constituted by or is a causal product of different individuals' acts" (Kutz, 10). Where both these factors are present, Kutz claims that the collective end goal informs one's actions of contribution in such a way that the contribution cannot be neatly described as something that resulted from an individual intention. "The defining characteristic of a participatory intention, then, lies in the form of [a] relationship between [the] individual act performed and the group act or outcome that rationalizes the [participatory intention]" (Kutz, 11). In addition, Kutz claims that there are different characterizations of this relation between the action and end goal. He exemplifies by labeling one type of relation as instrumental where "what the agent does helps cause the collective outcome" (Kutz, 10). For instance, if one were to help move a car (Kutz, 10) or step a certain way as part of dancing the tango with a partner (Kutz, 11).

One's end goal can be more individually or collectively focused, depending upon the kind of action which takes place. Recognizing this, Kutz claims that some actions may seem collective at the surface, but are individually focused. He gives the example of a traditional economist's conception of an

idealized competitive market, where "there are highly routinized forms of coordination in which agents see their actions as contributing entirely to their own ends" (Kutz, 10). An individually focused end goal requires individual intentions, while a collectively focused goal requires participatory intentions.

2.3.4 Metaphysical Baggage and Collective Agency

Using Tuomela and Kutz, Isaacs is able to formulate an account of how collective agency formulates intentions which lie outside of individual control. These intentions are able to capture dimensions of group intentions that cannot be attributed to an aggregate of individuals. In turn, each group member's intention is comprised of both individual and collective dimensions: the individual intention encompasses the conscious intent to make a contribution, while the participatory intent encompasses the relation between this contribution and the group's end goal. Still, invoking a conception of collective agency is problematic to the individualist, who may caution that it entails unnecessary metaphysical baggage.

This metaphysical baggage lies with the assumption that attributing agency to collectives requires attributing consciousness at the collective level (Isaacs, 67). Under this assumption, "intentions must exist in the heads of agents… [entailing that] the very idea of collective intentions would require a collective mind to house them" (Isaacs, 37). In essence, some individualists may argue that the inability of collectives to be conscious entities disqualifies them from having intentions. In other words, individualists reason that, "since collectives do not have heads in which intentions may exist, there are no collective intentions" (Isaacs, 37). Responding to this criticism, Isaacs differentiates between the nature of individual intentions and collective intentions. While individual intentions are the result of mental states, collective intentions result from a structure which enables a decision-making process.

Organizations and goal-oriented collectives both possess "a collective intentional structure which gives rise to collective intention and collective action" (Isaacs, 27), and it is this common feature which allows Isaacs to attribute agency. These structures create a decision-making process which enables the

33

group reason for pursuing an action to remain distinct from individual reasoning. Hence, the claim that there is a level of collective agency that is distinct from individual agency translates to the claim that the group structures "yield a level of intentional action that is distinct from the intentional action of the individuals who perform their… roles" (Isaacs, 29). Although the individual's actions may partially constitute the actions of the organization, these overall organizational actions flow from separate intentions than those of the individual (Isaacs, 29).

As a result, the degree of distinction between individual and collective agency depends on the level of structure the collective possesses. In an organization, there is a sharp disconnect between individual and the collective intention (Isaacs, 29), as the structures for group decision-making are highly evident in organizational policy. "When the corporate [organizational] act is consistent with, an instantiation or an implementation of corporate [organizational] policy, then it is proper to describe it as having been done for corporate [organizational] reasons" (Isaacs, 29). Meanwhile, though the distinction between individual and group intention is less clear, Isaacs claims it can still be understood in reference to the collective goal: "the end at which the collective aims" (37). Thus, in addition to the complex of individual intentions, Isaacs describes collective intention in terms of the relationships between individuals and the joint goal, as well as the "individual's understanding of themselves as standing in relation to others as members of a group in pursuit of a joint goal" (36).

2.4 Three Practical Examples of Collective Agency

2.4.1 Psychology and Behavioural Economics

Thus, in spite of the fear that collective agency has strange metaphysical implications; it can be understood holistically as the collective formation, through a decision-making process, of a group end goal. It is also understood in terms of the participatory intentions which lead to the realization of this group end goal. This theoretical framework of collective agency is also supported in its application to

other areas of academic research. In the fields of psychology and behavioural economics, game theory, and neuroscience and evolutionary theory, notions of a group end goal and participatory intentions complement existing research in the field. Additionally such application provides solutions to what appear to be contradictions between the existing theory and research findings when approaching the issue from an individualist perspective.

In addition to theoretical arguments that reveal there to be collective intentions and therefore collective agency, there is emerging evidence in the fields of psychology and behavioural economics, game theory, and neuroscience suggesting that intentions cannot be fully acted upon by any one person. In psychology, there is research which demonstrates that purely collective intentions do factor into moral decision-making. Some psychological experiments conducted by Chen and Li (2009) and Chen and Chen (2012), reveal that a mere categorization into groups could produce group-contingent social preferences (Cadsby et al, 4). When interacting with in-group members, subjects exhibited "significantly more altruism, reciprocity, forgiveness and overall efficiency maximization than when interacting with an out-group member" (Cadsby et al, 4). Building on these experiments, Cadsby, Du, and Song investigated whether group membership influences moral decision-making by testing whether subjects would lie and cheat to benefit their in-group members.

In the experiment, the subjects were fulltime undergraduate students who were enrolled at two different universities; Zhejiang-University as the in-group members, and Shanghai University of Finance and Economics as the out-group members (Cadsby et al, 7). An allocation task of dividing a sum of money, 50 Chinese Yuan (¥50), between an in-group member and an out-group member was set up, where only Zhejiang-University students were designated to be allocators (Cadsby et al, 7). In one treatment, the allocators report a die-rolling outcome and in another, they make the choice at their discretion (Cadsby et al, 6). In the die-roll treatment, however, allocators have the option to cheat by reporting a higher number than was actually rolled. To ensure that the allocators' decisions were not

governed by any direct or indirect self-interest, both the recipient and allocator's roles were fixed to ensure no reciprocity (Cadsby et al, 7). Further, allocators received a fixed salary for their participation, regardless of their decision (Cadsby et al, 7).

In the free-choice treatment allocators favoured their in-groups significantly more than their out-groups, confirming once again that group membership alone can influence one's preferences (Cadsby et al, 14). Yet, in addition to group membership affecting preference, Cadsby Du and Song reveal that it also influences moral decision-making. In the die-roll treatment, a two-sided binomial test determined that the reported results of the die-roll were inconsistent with predicted results (Cadsby et al, 14). This suggests that some allocators are lying to favor members of their in-group (Cadsby et al, 15). Interestingly, reported results of the die-roll treatment favoured their in-group members less than the free-choice treatment, though not significantly (Cadsby et al, 15). In versions of the experiment where the allocator divided money between themselves and their recipients, significantly more money was allocated to one's self than in the version which benefitted the in-group only (Cadsby et al, 16). The moral burden of cheating significantly reduces the average amount that the allocator allocates to themselves, while it has no such effect on allocation to an in-group member.

Interpreting these results from a philosophical lens, moral agents can shift their focus to understand problems in terms of their in-group rather than themselves individually. In other words decisions that one would make for the sake of their group are not ones that would necessarily be made for themselves. Moreover, because group membership can factor into one's moral decision-making, there is evidence to warrant the fact that group membership is morally significant. Recalling Isaacs' portrayal of collective intention as the relationship between the individual and group goal, as well as the way one understands one's self in relation to others as members in pursuit of a joint goal, lends support to the idea that collective agency is ontologically separate from individual agency. After all, there are factors which can influence a moral agent's decision-making which lie outside the scope of individual decision-making.

36

2.4.2 Game Theory

This psychological evidence is supported further through observations about cooperative game theory, as examining game theory without reference to collective intention, such as group membership or a joint goal, provides an incomplete analysis of individual decision-making. As a result, the individualistic elements of game theory, strategic responsiveness and common knowledge requirements, fall short of determining optimal individual choices (Kutz, 7). To illustrate, Kutz formulates an example where two friends intend to travel together to a city, and both would prefer to do so by plane rather than train (8). Ordering preferences, the optimal result would be where both friends travel to their destination by plane. Thus the intuitively obvious choice would be where both friends buy plane tickets, assuming that the other would likewise buy a plane ticket. Yet in cooperative game theory, Kutz specifies that each person "should only choose the plane if [they] think [the other] will choose the plane too" (8). The strategy is problematic, however; thinking in terms of individual decision-making, the other person also relies upon the agent choosing the plane. This means that each person "is in no better position to make a determinate choice of planes over trains" (Kutz, 8). Individualistic strategic reasoning renders the agents' preferences to match the other indeterminate with respect to choosing planes or trains (Kutz, 8).

Determining why this intuitively rational choice is not attained through game theory, Kutz concludes that the rational choice is not at odds with game theory. Rather, game theory fails to determine the collectively optimal outcome as a rational choice (Kutz, 8). Including this factor as a game theory strategy involves making the "further assumption [that] each of us will, in anticipation of the other, opt for the collectively rational outcome" (Kutz, 8). Thus, in choosing whether to buy a plane ticket or train ticket, the optimal outcome occurs where each person would think of buying a plane ticket as a contribution to the collective outcome where they take the plane together to their destination.

2.4.3 Neuroscience and Evolutionary Theory

Meanwhile Michael Gazzaniga has conducted research on neuroscience and social decision-making that supports notions of collective agency. In particular Gazzaniga questions how we came to operate by moral-social rules, and whether our cooperative nature results from responding to group dynamics rather than upholding personal rules (146). One observation he has made is that contributing to collective end goals is necessary in order to respond to a social environment.

Gazzaniga observes that, in transitioning to having a dense population with an agricultural and sedentary lifestyle, humans have adapted to a social world (146). For instance, the human population alive in 1950 was equivalent to the number of humans who had previously been alive in the history of the world, and presently there is a population of 6.7 billion - more than twice the population alive in 1950 (Gazzaniga, 146). Yet, the results of this transition to a more populated world contradict what one might expect approaching the issue as an individualist. In spite of this dramatic transition to interacting with more people, "we as a species are becoming less violent and get along rather well" (Gazzaniga, 146). Further Gazzaniga claims that particularly violent individuals are few and far between, estimated at about five percent of the population (146).

In response to this problem, Gazzaniga examines neuroscientific and evolutionary theory in terms of the formation of collective intentions and end goals. Interestingly, he finds that the transition towards a more peaceful society is compatible with collectivist understandings of such theory. In terms of neuroscience, one example of this is Vygotskian intelligence hypothesis, which rests upon the premise that higher cognitive performance in a social group requires cooperation in addition to competition (Gazzaniga, 148). It claims that "while cognition in general was mainly driven by social competition, other aspects of cognition that they consider to be unique to humans... were driven by or were constituted by social cooperation" (Gazzaniga, 149). These unique cognitive elements include the skills of forming shared goals, joint attention, joint intentions, and cooperative communication (Gazzaniga, 149). Further

these cooperative skills were paramount to creating complex technologies and social institutions (Gazzaniga, 149).

In addition to a higher cognitive performance, skills to engage in collective action are necessary to promote evolutionary success among primates. This is primarily explained through the Baldwin effect, which describes the evolution of the ability to respond to various particular environments (Gazzaniga, 153). The ability to respond to various environments is accomplished through the evolution of genes for plasticity rather than genes for particular phenotypes (Gazzaniga, 153). Ultimately, this means that "although the phenotype generated is context-dependent, the ability to respond to the context has a genetic basis" (Gazzaniga, 153).

Applying the Baldwin effect to determine a genetic basis for the phenotypic expression of socially cooperative skills, fixed genetic traits are for one's tendency to socially acquire skills, rather than their learned ability to socially acquire skills (Gazzaniga, 155). He claims that if a complex behavioural trait were socially learned, where one must learn it from others and are unable to discover it themselves, selection pressures will be created "for genes that make individuals better at socially acquiring [the behavioural trait]" (Gazzaniga, 155). In part, these selective pressures are triggered by a social environment – where individuals have already learned this particular behavioural trait. "After all, there will not be any advantage to a gene that makes you better at learning P from others, if there aren't any others to learn [the behavioural trait] from" (Gazzaniga, 155).

2.5 Summary

In summary, collective responsibility theory examines how individual actions are affected in a morally significant way by their interaction with the actions of others. An important aspect of this field is determining whether collectives have agency. While individualists accept that group membership can affect individual actions, they believe that the group intentions driving such an affect can be reduced to a complex web of individual intentions. In contrast, collectivists believe that group intentions are

39

irreducible, and are the result of a collective agency. Using concepts from Tracy Isaacs, Christopher Kutz, and Raimo Tuomela, I argue for a collectivist account of collective responsibility. This is supported with evidence from the fields of Psychology and Behavioural Economics, Game Theory, and Neuroscience and Evolutionary Theory. My motivation for making such an argument is that I believe that the concept of collective agency confers some interesting implications for IPC (interprofessional collaboration) in health care. In the following chapter, I will expand upon conceptions of collective structure in order to apply a collectivist analysis to IPC in health care.

Chapter 3

Applying Collective Responsibility Theory to Solve Health Worker Inequalities

3.1 Introduction

In the previous chapter, collective responsibility theory was discussed, with a focus upon conceptions of collective agency. Specifically, I sought to establish that collective agency exists on another conceptual level than individual agency, such that it is irreducible. I discuss three practical examples of this revealed in the fields of behavioural economics, game theory, and neuroscience and evolutionary theory. I then discuss how this collective agency can manifest in, not only highly coordinated organizations, but also goal oriented collectives, which are less coordinated. These theoretical concepts are meant to highlight the ideas useful to developing a theoretical framework which can better understand the inequalities between medicine and nursing disciplines.

My goal in this chapter is to apply these theoretical concepts to the health care system in great detail. By applying these concepts, I hope to identify some underlying ways in which hospitals perpetuate inequalities between physicians and nurses. In the following subsections, I will identify and explain the structures in the health care system which facilitate collective decision-making formally as an organization, and informally through goal oriented collectives. I begin by expanding on the nature of the formal structures governing organizations and the promising initiatives to improve collective decision-making within IPC teams. I then discuss the role of goal oriented collectives in the health care system and how altering professional cultural values might facilitate these formal organizational changes. Concepts of tightness, centrality, and essentiality are then introduced in order to make recommendations on the kinds of alterations to the aforementioned structures that will promote greater transdisciplinary collaboration in health care.

3.2 Health Care and Organizational Structure

3.2.1 Corporate Internal Decision Structure

As shown in the previous chapter, a defining feature of organizations is a clear organizational structure and policy. Peter French gives an account of the nature of corporate agency in terms of his concept of the Corporate Internal Decision Structure (CIDS). Describing internal decision structures used by organizations, French stipulates two structures which are indicative of a collective agency. Firstly, he describes "an organizational or responsibility flow chart that delineates stations and levels within the corporate power structure" (French and Surber, 76). This is coupled with what he labels 'corporate decision-recognition rules' – corporate policy which regulates decision-making (French and Surber, 76). These two components of CIDS allow for the "subordination and synthesis of the intentions" (French and Surber, 76) of individuals in order to achieve an overarching collective decision. The implication of this is that there is no need to refer to the intentions of individuals to understand organizational intent (Isaacs, 29). In fact, "an organization may intentionally pursue a course of action that is not the action that [any individual] in the organization intended" (Isaacs, 30).

French uses CIDS along with "his principle of act re-description... to relate an individual's actions and moral responsibility for them to those of corporations" (French and Surber, 75). This means encompassing distinct individual decision-making into one's description of a corporate decision. According to French an action that results from organizational intention relies upon the proper functioning of the organization's CIDS (French and Surber, 76). This means that a corporate intentional act can be understood in terms of separate individual actions taken on as part of honouring one's role in the corporate internal decision structure (French and Surber, 76). Without this context of honouring one's role in the CIDS, these acts would have no collective dimension.

In the health care context, Silverman likewise discusses the complex relationship between the actions of individual members of a collective and "the influence of the contextual aspects of the

organization on their behaviour" (205). He describes the distinction between individual and organizational collective agency as an issue of control. Specifically in the healthcare setting, Silverman claims that we often forget that many clinical health care issues are beyond the control of the individuals who carried the problematic actions out. To account for such a lack of control, he describes patient care as being "situated in a web of organizational patterns relationships, structures, and processes" (Silverman, 205). As I will explain later in this section, the delivery of patient care cannot merely be individualistic, as it is partially influenced by organizational dynamics.

Describing the relationship between individual actions and the CIDS which gives these actions collective dimensions, French elaborates on the connection between the CIDS, individuals and their intentions, and the corporate intentional act (French and Surber, 77). He maintains that although descriptions of corporate actions include these individual actions, corporate intentional action is not reducible to the results intended by the individual members of the corporation (French and Surber, 77). This means that, while organizational collective intentions and individual intentions can align, it remains a possibility for individuals to act upon completely distinct intentions. "Individuals may well have their own personal reasons, beliefs, and desires in acting as they do while the corporation may still properly be said to have acted on the basis of corporate intentions" (French and Surber, 77). These separate intentions mean that an ethical judgement made about an organization's CIDS does not necessarily coincide with our ethical judgements of the individuals who fulfill their roles as part of this structure.

Even where an individual can make an executive decision about an organization, those actions are still moulded by corporate policy – resulting in a corporate intention. Isaacs illustrates this point with an example about the artistic director of the Stratford Theatre Festival who "might, for example, have a carte blanche to select the full slate of plays for the next season" (30). Because the director's selections must honour the "festivals mission to offer a mix of Shakespearean productions and more accessible, crowd-pleasing works" (Isaacs, 30), her resulting selections may differ from those she would make if she were

43

"at liberty to stage only what she liked" (Isaacs, 30). Regardless of her personal tastes, the director's decision becomes redescribed as the festival's decision when it is constrained by the goals and mandate of the organization (Isaacs, 30). Within these organizational constraints, the director is at liberty to guide her decision-making according to her preferences. In so far as these preferences have little bearing on organizational goals and mandates, they remain on the individual level.

To summarize, organizational collective decisions can be identified through the use of corporate internal decision structures in the health care system. Corporate internal decision structures (CIDS) represent a collective agency that is ontologically distinct from the agencies of individuals. This is because; CIDS guide individual contributions by constraining these contributions within the goals and mandates of the organization. Further, CIDS can be used to attribute a collective intentionality to individual executive decisions in an organization. After all, executives are not exempt from incorporating the organization's goals and mandates in their decisions.

3.2.2 Understanding Organizational Collectives to Modify CIDS

Understanding French's view that the collective intentions of organizational collectives is attributed to CIDS, and that these systematized intentions remain conceptually distinct from actual individual intentions, there are two important implications which are applicable to the health care system. Firstly, that an organizational collective intention to improve nurse job satisfaction and resolve disparities between physicians and nurses can be achieved. Such an intention is attainable through changes to the CIDS which govern the treatment of health care professionals within the health care system. These changes would mainly occur through hospital policy in order to reduce the administrative barriers which prevent nurses from contributing directions for patient care.

Analysing the problems outlined in Chapter One, there is a high degree of potential for resolution to the issue using formal systemic means. For instance, among the major causes of moral distress which

44

Corley et al identified, there are a number of factors which fall under systemic organizational barriers. Among these are compromises to "treat... patients as objects in order to meet institutional requirements... withdrawal of treatment without nurse participation in the decision... [and] disregard for patients' choices about accepting or refusing treatment" (Corley et al, 382). Specific issues with hospital policy arise from nurses' concern for adequate patient care conflicting with health policies that aim to cut costs (Corley et al, 383). This conflict is especially present where nurses feel they are not spending adequate time dedicated to patient care, which can incur costs (Corley et al, 383).

It is especially important to resolve such conflicts because of the negative effects upon nurses' mentality towards the health care system, where they feel a loss of integrity. The effects of organizational conflicts are demonstrated by Corley et al, who found that the health care organization "was not receptive to supporting nurses in conflicts involving physicians, a frequent source of moral distress" (384). Moreover this lack of support occurred systemically rather than among individual nurses with problematic behaviour. This is because the ethical issues encountered by nurses were reported to have arisen in predictable settings, and prioritized administrative values in favour of hospital rules (Corley et al, 383). Hardingham affirms this by quoting Chambliss, who claims: "remove a nurse with an ethical problem from the hospital, replace her, and her replacement will encounter the same problem. The problem is not of the person but of the system" (130). Thus, detailed efforts to revise hospital policy to redirect cost management must be undertaken such that cost management does not come at the expense of adequate nursing care.

Furthermore, nurse job satisfaction can be improved through modifications to policy that addresses external conflicts indirectly affecting nurses. These modifications include legal and policy structures directed towards managing bioethical problems such as conflict between the interests of patients and family members, disagreements over treatment decisions, and ineffective efforts for improved patient experience (Corley et al, 383). By turning our attention to improving policy that

redirects cost management from adequate intention to improve patient care, facilitating nurse contribution to directing patient care, and managing external bioethical conflicts, we can reduce powerlessness.

In fact, such measures can improve the quality of nursing contributions in interdisciplinary work. This is evidenced in research where perinatal nurses were more involved in resolving ethical dilemmas affecting patient care when they perceived themselves to have more influence in their environment and were more invested in the patient (Corley et al, 383). Therefore, it seems that formal changes to the organizational structures governing IPC have the potential to vastly improve nurse job satisfaction by improving rates of moral distress among nurses. These changes ought to primarily focus upon balancing institutional measures directed towards efficiency and saving money with the need for better institutional support of nurses. Further, steps to mediate conflicts of interest and disagreements between professionals, patients, and patients' families ought to be rendered more clear through the changes to formal policy.

3.2.3 Improving Nurse Job Satisfaction and Patient Health with CIDS

Current research on the implementation of organizational decision-making structures in health care has yielded promising results; not only in improving nurse job satisfaction, but also in improving the quality of decision-making in patient care. In their qualitative study on nurse management, Laschinger and Wong report that some nurses claim that changes to increase the scope of chief nursing executives' responsibilities "provide opportunities for nurse leaders to demonstrate their leadership skills and play a greater role in decision-making within the new multidisciplinary program structures" (1). Yet the effectiveness of these changes to the scope of nurse executive responsibility is highly dependent upon formal and informal policy changes. These include formal "mechanisms, such as shared governance structures, professional practice models and strong communication mechanisms" (Laschinger and Wong, 4). Implementing these mechanisms along with informal initiatives to improve organizational commitment among IPC members, Laschinger and Wong report moderate to high levels of "transformational leadership behaviour used by senior nurse leader and themselves, job and role

satisfaction and job security, empowerment and organizational support, support for professional nursing practice, satisfaction with supervisor communication Influence in staff and policy decisions, patient care quality" (17).

In addition to the receptiveness of nurse managers formal structural changes in IPC, the implementation of a formal structural process can improve the quality of patient decision-making. Liberatore and Nydick conducted a literature review on the application of Analytic Hierarchy Process (AHP) "a decision making method for prioritizing alternatives when multiple criteria must be considered" (195), to patient health. He found that the use of AHP made significant improvements to patient participation in decision-making about their health. He exemplifies this by citing Singpurwalla et al, who compare the application of AHP to patient–physician shared decision making on menopause treatment and cosmetic eyelid surgery (Liberatore and Nydick, 199). Comparing the attitudes of patients and physicians towards using AHP in shared decision making, Singpurwalla et al found that both patients and physicians reported improved communication, and preferred AHP to conventional modes of doctor– patient decision making (Liberatore and Nydick, 199).

More encouraging is the evidence that this research is yielding changes to health care structure and organizational policy. A 2007 report from the Canadian Medical Association (CMA) recommends formal processes for conflict resolution, as well as clear definitions of the "scope of practice, roles and responsibilities of each health care professional on the team… [to be] understood and delineated in job descriptions and employment contracts" (8). This way, "issues can be dealt with in a timely and appropriate manner (CMA, 9). These recommendations also include the recognition that, while the physician may often be best equipped to provide clinical leadership, "many teams will exist in which the physician will have a supporting role, including those focused on population health and patient education" (CMA, 7). Thus, the CMA is open to making policy changes to IPC to provide nurses with more support and control over decision-making affecting patient care.

In fact, the CMA also recognizes that the formal structural changes to collaborative care are instrumental in serving the needs of patients and enhancing patient care (8). They do this by recognizing the patient as a member of the collaborative team insofar as they are a stakeholder in the decisions made about health. To this end, the CMA advises that "collaborative care teams should foster and support patients, and their families, as active participants in their health care decision- making, including measures of prevention and self-care" (5). In addition to improved communication between patients, their families, and the collaborative care team, including patients as part of IPC team entitles them to inclusion in discussions about their role as a team member (CMA, 5). This involves informing patients about their role in making informed decisions about their care as well as the role they play in improving their personal conditions (CMA, 5).

Thus, a health care system operates under a collective agency as an organization – where the connection between the health care system's collective agency and the actions of health care professionals lies in a Corporate Internal Decision Structure (CIDS). A CIDS lends a collective element to the actions of individual members, as members must incorporate organizational goals and mandates into their individual decisions. Hence, to resolve inequalities at the collective level requires that we alter the health care system's corporate internal decision structure. Specifically, these alterations should create measures to support and guide the mediation of conflicts between health professionals, the patient, and the patient's family.

3.3 Health Care and Goal Oriented Collectives

3.3.1 Core Values and Group Culture

Still, merely changing hospital policy can be problematic as there are limits to the control that organizational policies have over the actions of individuals. After all, in addition to a formal corporate internal decision structure, there are informal expressions of the health care systems' group agency that

can affect individual actions. This is significant to improving IPC as it reveals that modifications to policy ought to be supplemented with changes to these informal structures. Indeed, this claim translates to testimony about interprofessional collaboration which indicates that teamwork initiatives are mostly accessible to managers and administrators – only team-members familiar with policy. "Frontline nurses are not really into interprofessional collaboration; it's more the nurse managers" (Beales et al, 337). I believe that these informal expressions of collective agency can be conceptualized in terms of goal oriented collectives. In other words, an accurate understanding of collective agency within the healthcare system is one which considers both the decision-making structures which define health policy, and the processes which yield informal collective decisions made by hospital staff – an integral part of goal oriented collectives.

The process which governs these goal oriented collectives is the joint goal to honour a group culture. Silverman defines group culture "as the shared values that have been reflected on and articulated by the members of a cooperative group and have been accepted by them as normative for the culture of that [group]" (205). Yet in his description of group cultures, Silverman also makes note that group cultures highly influence organizational culture. He depicts decision-making to be driven by the underlying core values that govern a group culture (Silverman, 205). Meanwhile organizational processes, what French would refer to as CIDS, are some of the mechanisms through the core values are reinforced to ensure that decisions reflect the these values (Silverman, 205).

Silverman exemplifies this relation between group culture and organizational structure by relating core values to the kinds of organizations which would employ the right structure. One example he gives is of a corporate culture characterized by "rapid decision-making and no bureaucratic behaviour" (Silverman, 205). While these values would be efficiently honoured in a competitive deal-making environment, such as a merger and acquisition advisory firm, the CIDS put in place as part of traditional life insurance company would inhibit these values (Silverman, 205). Silverman also describes this relation

49

in terms of what group culture values an organization ought to strive for based on the systemic value which an organization promotes. "An organization in which managers place a very high value on customer service may want a culture that emphasizes values such as teamwork, good customer relations, respect, collaboration, and social responsibility" (207). Thus group culture is "a concept relevant to organizational life and... an integral aspect of many organizational change programs" (Silverman, 205). This concept ought to be taken into account to promote a strong organizational life – one which promotes a close relation between the core value that guides group culture and the organizational structures which maintain it.

3.3.2 Group Culture as a Limitation to Decision-Making

Thus core values integral to a group culture serve as a primary influence on decision-making, whereas organizational structures serve to enforce these group values. Yet Hardingham, who supports this claim, also warns that group cultures in health care can limit decision-making, particularly among nurses. She claims that the confidence needed to make moral decisions greatly depends upon whether the work environment is a moral community, where workers are encouraged to voice ethical concerns in a setting that promotes shared understanding and mutual respect (Hardingham 132). Further, this group culture is vital to maintaining a climate which encourages the development of professional values and identity (Hardingham, 132). From this, she concludes that the social climate of the nurse's working environment is highly significant to the decisions nurses can make.

Hardingham also reports that the social climate that pervades healthcare is one of conformity, rather than the moral community she describes. She observes that "nurses who were unable to conform to ward routines and the norms of the team or the values of the charge nurse were forced to move to another job or to leave the profession" (Hardingham, 132). This observation of a social climate of pressure to conform reinforces a situation that Hardingham experienced herself as a registered nurse. In this situation, she notes that her responsibility and professional role granted her the administrative authority to act upon

50

an unethical situation. As an administrative coordinator, Hardingham held administrative authority over

administrative decisions made during nights weekends and holidays (128-9). Her authority was meant to

substitute that of a day manager, requiring her to do rounds of all the units in the hospital (Hardingham,

128-9).

Despite this authority stipulated by the organizational structures of the health care system,

Hardingham found that the environment governed by group values of submission and conformity

suppressed her ability to make a decision.

> "I was in the emergency department one night when a patient was
> brought in with an overdose. As I was there, and they were short-staffed,
> I went into the trauma room to assist as recorder. The patient was a First
> Nations woman who was very upset and resisting medical care. She was
> in four-point restraints, was very verbal in her resistance, roundly cursing
> the staff. The emergency physician, after demanding several times that
> she 'shut up', took a washcloth and stuffed it in her mouth to silence her.
> I was dumbfounded! I stood there for a moment debating whether or not
> to intervene as the rest of the team laughed. A combination of fear,
> uncertainty and the feeling that no one else in the room would understand
> led me to question my values. I resisted doing what I felt was the right
> thing to do. In the end, I handed the record sheet to another nurse and left
> the room." (Hardingham, 129)

Although the individual actions of the physician were clearly wrong, what is more problematic is the

inability for Hardingham to respond to the situation according to hospital policy – hence being unable to

carry out the collective intention of the organization. Upon examining her actions and intentions in her

situation, Hardingham claims that her intuitive response to the situation was to "walk over to the patient,

remove the washcloth and say why I believed the doctor's act was wrong"(129). Yet she felt incapable of

acting upon this response, not because of moral uncertainty, but rather that acting upon the response was

not possible. She states that, "I now wish that I had found the courage to [act], but [voicing my dissent]

did not seem to be open to me at the time" (Hardingham, 129). Based on this strong informal barrier to

contributing her values, Hardingham concludes that the culture of the emergency room in that hospital was such that she "set aside deeply held (and publicly professed) beliefs, values and principles" (129).

In addition to the caution and wariness which Hardingham holds for a group culture which only holds the core values of medicine, Silverman warns against a corporate group culture which prioritizes profit over patient health. Though this is an acute concern in a privatized health care system, considerations for business values still plays an important role in a publically funded health care system. He claims that "business values focussed on service quality, enhanced efficiency, and financial solvency is quite different from professional values focussed on the protection of patient welfare" (Silverman, 207). As a result of this difference the outcomes honoring business values risk conflicting with outcomes of improved patient health. In spite of this problem, however, Silverman notes that business values are being treated synonymously with professional values in the current health care system (207). To prevent prioritizing business considerations above patient health, Silverman recommends a "robust business ethos that will regulate and limit the impact of financial considerations on patient welfare" (207).

3.4 Conceptualizing the Problem in Collective Responsibility Theory

3.4.1 Tightness and Centrality

As stated in the Canadian Medical Association's report, the organizational policy which guides interprofessional collaboration needs to make clear the kind of role that physicians and nurses carry out in patient care. Specifically, there needs to be recognition of the decision-making and leadership roles that nurses take on. In his interview with Dainty et al on the measures which ought to be taken to optimise teamwork, a physician maintains that one needs to cultivate and support "key leadership from the physician and nursing groups", in order to render role definition and diversity and sensitivity training useful (9). There also ought to be a means to identify the degree of patient involvement as part of the collaborative team. Using three concepts important to collective responsibility theory, tightness,

centrality, and essentiality, I will make some recommendations on the kinds of theoretical factors which ought to be taken into account in implementing these changes.

In her explanation of collective agency, Tracy Isaacs discussed various factors relating to the nature of organizational and goal oriented collectives. One of these is tightness, which refers to the level of coordination present among members of the collective. Isaacs describes this as the "common knowledge and/or mutual responsiveness to the intentions of the other members" (41). While in each collective there needs to be some members who act with coordination and interdependence, there are varying degrees of flexibility in collectives which allow for members to act upon less coordination. To illustrate this, Isaacs draws upon the example of a multi-location fundraiser involving thousands of participants nation-wide (44). She notes that "it is surely impossible that anyone knows all of the other participants or even who all of the other participants are" (Isaacs, 44) – and thus cannot all coordinate with one another. Despite this, Isaacs is still willing to attribute a collective agency to such a group, as the extent of coordination between members of the fundraiser distinguishes it from a parallel action, coincidental joint action resulting from an aggregate of individuals (48). In this way, Isaacs sets the minimum tightness for collectivity very low – some coordination is enough.

The diverse range of tightness which characterises collectives allows for members who make varying degrees of informed contribution to the collective action. Depending on the kind of contribution one makes, Goodin and Lepora claim that these contributions carry various degrees of centrality. They define centrality in terms of two separate factors. Firstly, one's degree of centrality is determined by the "magnitude of contribution to the principle [morally relevant action]" (Goodin and Lepora, 66). In other words, other things being equal, contributing more to the morally relevant action entails more consequential moral responsibility than those who contribute less (Goodin and Lepora, 66). To measure one's centrality, Goodin and Lepora develop two main categories; co-principles, and contributors. The most central category is that of being a co-principal. Rather than being a simple participant in the

53

collective action, one constitutes the core value of the action itself, weather in developing a collective

intention or carrying out the act itself (Goodin and Lepora, 36).

Meanwhile group members who are less central to the collective act are labeled as contributors.

These members participate in furthering the core value "without their acts in any way constituting part of

that principle [value in itself]" (Goodin and Lepora, 37). These contributory acts "'give access' to the

principal the morally relevant action, facilitating it or perhaps even making it possible" (Goodin and

Lepora, 42). Goodin and Lepora clarify that these contributions can only ever be causal as contributors

more often carry out the plans of the co-principals rather than formulating the collective plan. To do this,

they distinguish between plan-makers, who are the agents who share in formulating the plan, and plan

takers. Plan-takers are defined as the "agents who have no role in designing the plan, and follow the plan

as it is given by others" (Goodin and Lepora, 42). In spite of this plan-taking role that characterizes

contributors, Goodin and Lepora set a minimum condition that contributors must have some awareness of

the plan.

A problematic aspect of this classification of centrality is the characterization of collaborators in

this theory. In a setting of health care collaboration, Goodin and Lepora would define nurse collaborators

as having a contributory role rather than a co-principal role. This is because each collaborator takes on

distinct types of actions to realize a plan. These actions involve significantly different skill sets, data or

disciplinary perspectives to offer, such that only one disciplinary perspective can take on an active

planning role (Goodin and Lepora, 43). This interdisciplinary understanding of collaboration encourages a

culture of conformity – while physicians and nurses may work together, nurses must set aside their beliefs

and values and adopt a contributory, plan-taking role.

Hence, having applied concepts of tightness and centrality in order to understand the systemic

barriers which limit nurse processes for moral decision-making; it is clear that in some cases, for instance

among advanced care nurse practitioners and physician assistants, nurses ought to have roles that are

defined to be more central. Though nurses do, in fact, hold a very central role in patient care they are often understood in terms of a more traditionally based, plan-taking conception of nurses. Defining nurses in terms of the actual centrality of their impact on patient care would reflect their high degree of involvement in the planning process which determines actions taken on by the collaborative team. The changes which clarify this more central, plan-making role will mostly occur through modifications to health care policy – specifically policy defining nurse job descriptions.

In addition to these policy changes, there ought to be structures put in place to help honor these policies which stipulate plan-making nursing roles. One such structure is the greater awareness of and accessibility to programs meant to facilitate nurses in moral decision-making. Corely et al claim that many nurses are unaware of the support services meant to assist nurses in collaborative environments. "Despite the Joint Commission on Accreditation of Health Care Organizations' requirement that organizations have ethics committees, nurses may not know that they exist or that they are available to them" (Corely et al, 387). Many ethical concerns reported affect nurses day to day (Corely et al, 387), and may require assurance and administrative support in order for nurses to feel comfortable voicing their moral concerns in an environment that has traditionally suppressed their input. Therefore, the health care system needs to make these support services more available as a platform which promotes nursing perspectives on moral issues in health – such as "the impact of inadequate staffing or incompetent health care workers" (Corely et al, 387).

Another structure which can help reinforce these policies is the use of formal teamwork training to encourage group interactions that create less resistance to nurses taking part in central plan-formulation. Ajeibge et al point to the effectiveness of teamwork training in creating such group interactions in a study on emergency ward collaboration, where an interventional group was exposed to a formal teamwork training program (1). In addition the interventional group implemented orientation teamwork training for new staff, and early refresher courses among current staff (Ajeibge et al, 2). The

interventional group was then compared to a control group, which "did not participate in any formal nurse-physician teamwork training and teamwork was not operationalized in their emergency departments" (Ajeibge et al, 2).

Ajeibge et al report a significant difference between the job satisfaction among the interventional group staff and the control group staff (4). This job satisfaction can be attributed to collaboration skills such as "problem solving strategies; communication; plan execution; workload management; team structure and climate maintenance; and skill improvement" (Ajeibge et al, 5). Perhaps the most notable effect of these skills was improved group work cohesion which determined more that 51% of nurse job satisfaction (Ajeibge et al, 2). Therefore initiatives to implement formal teamwork training are recommended in order to create a team environment which encourages nurses to take on plan-making roles.

3.4.2 Essentiality

Thus, even in an interprofessional context which seeks to promote teamwork, policy which defines nursing roles as collaborators uphold inequalities by keeping nurses in a plan-taking roles, with no opportunity for involvement in making plans. This is made more problematic by the fact that determining the degree of one's centrality necessarily involves judgements of essentiality. The degree of one's essentiality measures the extent to which one's action is "essential... to executing the plan, to making what is planned actually occur" (Goodin and Lepora, 60). A clear sign of essentiality among individual group members lies in being an 'individual difference-maker' where if one acted differently, one would change the outcome of the action (Goodin and Lepora, 64). By defining nurses as collaborators, one seems to imply that their actions are less essential to realizing the health care system's goals as an organization.

Yet one can remain essential in a secondary sense by making vital causal contributions to the collective act. Goodin and Lepora claim that "a secondary action is... essential to the principal

56

wrongdoing when [it] is a necessary condition for the execution of the [act] in every one of the possible ways in which the wrong might be executed" (61). In this way, judgements of centrality of nurses which label them as mere contributors do not discount the significance or importance of nurses' work – nurses can remain essential to the health care system, to a degree.

Still, a contributory role does not achieve complete essentiality as long as it remains causal. Although a plan-taker might be essential to implementing the co-principals' plan, they lack "the particular kind of contribution involved in 'making' (formulating) the plan" (Goodin and Lepora, 71) – without which the plan could not possibly be carried out. Thus to ensure one is fully essential in the organizational action when their action is partially constitutive of the principal or core value of the organization. This means that, modifying the core values to include those held by nurses improves more than the group culture which governs the decisions made by health professionals part of goal oriented collectives. It also optimizes organizational structure to acknowledge the full essentiality of nurses, especially those involved in interprofessional collaborative teams.

3.4.3 Implementing Values of Care

One way to encourage more diverse core values which encourage a better group culture, as well as more structural essentiality for nurses, is encouraging the perspectives, methods, and skills which are motivated by care ethics. As discussed in Chapter One, care ethics is a relational conception of patient care which, in addition to patient well-being, emphasises a harmonious relationship between the nurse and patient. In this way, nurses' actions follow from principles of significance which, in part, motivate the organization's actions and govern the group culture in goal oriented settings. Recently, these care ethic values have been stifled in the educational setting – where schools of nursing place more emphasis upon the scientific aspects of patient care rather than interpersonal values. Nursing instructors familiar with educating physicians about compassionate caring are reluctant to teach nursing students a similar curriculum (Davis, 13). Davis notes that the rationale of these instructors is that "studying the softer aspects of nursing

reverse the hard-won gain in respect that nursing has made in the eyes of physicians and patients" (Davis, 13).

In addition to this, many educators carry the perception that medical students need to be more compassionate while nursing students were naturally empathic care providers. This is exemplified in one nursing instructor who, claimed that teaching nursing students about values of care ethics is redundant, as "nurses automatically ha[ve] more 'narrative sensibility' than physicians" (Davis, 13). Yet this assumption comes at the expense of professional values and identity, where nurses who were once part of a caring profession now feel that they "are little more than paper pushers" (Ballard et al, 175). As a result of this change of focus from care ethics to administrative rule-following, feelings of uncertainty and powerlessness have left nurses "unable to clarify their own roles to patients, administrators, society, and themselves" (Davis, 13).

Imparting a strong sense of care ethics in nursing education can be accomplished through the inclusion of humanities in the nursing school curriculum. After all, a greater presence of humanities in nursing education would develop skills such as compassion and social conscious, supplementing scientific and technical knowledge to allow nurses to develop a greater focus upon "the complexity of the human experience" (Ballard et al, 176). Without such a humanitarian focus, Ballard et al argue that "the uniqueness and justification of the existence of the nursing discipline is lost" (176). Thus by including humanities education as part of the nursing curriculum, the "broad interrelationship... [between] caring attitudes and empirical knowledge required to practice quality health care" (Ballard et al, 176) that encompasses a strong care ethic value will be held be nurses to motivate their decision-making.

Interestingly, Ballard et al report a direct relationship between a care ethic education among nurses and skill sets which improve the moral decision-making and job satisfaction. One skill is versatility, which would assist nurses in responding to and innovating new care techniques in the health care system (Ballard et al, 176). Secondly, nurses would develop skills in order to effectively analyse

values and judgements. This is useful as the health care system "becomes more and more complex and the allocation of resources becomes more challenging" (Ballard et al, 176). Thirdly, care ethic values enable nurses to maintain caring connections with patients and health care professionals (Ballard et al, 176). This skill allows nurses to preserve an environment of relational care which would otherwise be rendered complex and impersonal (Ballard et al, 176). By preparing nurses for "the challenges and rewards of nursing practice" (Ballard et al, 175), the inclusion of arts and humanities education to promote nursing values is suggested in order to instill the caring values which motivate nurse decision-making.

These skills gained through the integration of humanities education into the nursing school curriculum are supplemented by the teamwork skills that could be gained by implementing professional coaching on care ethics values. Ajeibge et al support this notion in collaborative settings, where teamwork can vastly improve job performance. They claim that "close working relationships and reliance on each other allow a team to do collectively what one staff member cannot do alone" (1). These dynamics can lead to positive outcomes such as greater communication, greater efficiency, and more trust between health workers. Understanding team dynamics is also especially pertinent in busy settings where health workers have time-restricted access to consulting the appropriate policy. For example, emergency wards have chaotic conditions which are characterized by a lack of adequate information about incoming patients, and a rapid movement of events (Ajeibge et al, 1). Therefore, it is important that the formal structural changes to hospital policy involve measures to include care ethics in the curriculums of medical schools and schools of nursing. This ought to be supplemented with continued professional seminars to encourage diverse professional approaches to patient care and enhance the quality of teamwork.

3.5 Summary

In summary, the disciplinary inequalities which create moral distress and poor job satisfaction among nurses can be better understood in terms collective responsibility theory, the relevant collectives being the organization itself (governed by CIDS) and goal oriented collectives (governed by core values). Looking

at the health care as an organizational, the internal decision structures of the health care system neglect to give nurses support when they encounter disciplinary conflicts. Further these structures challenge nurses' initiatives to improve patient health, so that the organization can save money. Applying notions of centrality to this problem, it is clear that nurses are treated as secondary contributors rather than primary co-principals. In other words, nurses are portrayed as acting on the plans of others rather than as group members who take on an active role in the planning process. Modifications to policy, formal team training, as well as greater accessibility of services that facilitate nurse perspectives on moral decision-making are recommended to improve the state of nursing as defined by organizational structures in health care.

Yet such changes can only do so much, as organizational structures are meant to enforce the core values that govern group culture. This group culture determines decision-making within goal oriented collectives. As it stands the core values currently propagated in the health care system are technical or scientific in nature, and do not incorporate nursing values of care ethics. Such an environment or group culture therefore stifles nurses from voicing their moral concerns or giving input into decision-making – even where they do have the structural authority to voice these concerns. This is caused by a problem of essentiality, where decisions to exclude nursing values necessarily render nurses less essential since they are unable to fully engage in plan-making. In order to change these core values, greater emphasis must be placed on humanities in the nursing school curriculum. In the next chapter, I will attempt to reconcile these proposed changes to organizational structures and core values, with health care hierarchy – which is sometimes necessary in decision-making processes.

Chapter 4
Reconciling Hierarchy with Equality

Introduction

In the previous chapter, disciplinary inequalities between physicians and nurses were contextualized in the theoretical framework of collective responsibility. Specifically, two concepts were used to characterize the health care system as an organization, and the informal goal oriented collectives of health care practitioners who work together to deliver patient care. Adjusting core values to include nursing values such as care ethics would shift group cultures so that nursing contributions to plans will be more essential to the planning process. Meanwhile, the corporate internal decision structures of the health care system need to be altered in order to lend support to nurses in taking an active role in the planning process.

In this chapter, I will focus on hierarchy as a barrier to these solutions I proposed. Sometimes health care hierarchy seems essential, as environments in urgent care and emergency wards necessitate quick decision-making. Further, there are also areas of specialization which make some workers most qualified to make decisions. In my analysis I consider that the duty to obey physician authority is sometimes instrumental to improving patient health. Yet evaluative duties, duties to critically examine and question problematic physician directives, ought to be prioritized above duties to obey. I conclude that the resolution between resolving disciplinary inequalities and honoring hierarchical structure in health care lies in predicting where duties to obey are superseded by evaluative duties.

4.1 Rational Hierarchy and the Physician-Nurse Relationship

4.1.1 Rational Authority and Purpose

A clear obstacle to resolving disciplinary inequalities between physicians and nurses is the structural hierarchy that place physicians in positions of authority and nurses in a position of deference. In order to address how hierarchy is implicated in resolving physician-nurse inequalities, it is important to determine the nature and potential justifications of such hierarchy. Examining the nature of the authority that defines the physician-nurse relationship, May finds it exhibits the characteristics of rational authority. In this subsection I will explain May's analysis of physician-nurse hierarchy, which I shall refer to as the rational authority model of hierarchy. He defines rational authority as "authority which imposes an obligation (to obey) because there are 'reasons for an action'" (May, 224). By virtue of its dependence on reasoning, rational authority differs from authority of office, in other words authority grounded in one's role as an official – for instance the authority of a police officer, or of the president of the United States (May, 224).

Since rational authority is grounded in reasoning rather than mere position, May finds two implications that characterize such authority. Firstly, he describes rational authority as being purposive in nature (May, 224). This means that the justification of rational authority is based upon some purpose, where its achievement provides the reason to comply with the authority's directives (May, 224). May exemplifies this with traffic law, where the justification for the authority of the law lies in its purpose, which might be "to achieve order in transportation" (May, 224). Because compliance to the traffic law will bring about this purpose of ordered transportation, traffic law provides reasons for compliance and ultimately serves as a rational authority.

The reasoning which grounds physician authority comes from their credentials. According to May, "physician training... is designed to enable [them] to assess the best treatment... while the nurse's training is designed to enable her to understand the order in question and the effects which will result" (225). Medical training therefore aligns the physician's decisions with the improvement of patient health:

the purpose of the health care system. After all, "generally the reason a patient goes to a physician is the expectation that doing so is the most likely way to get successful treatment" (May, 225). On a secondary level, the purpose of the health care system is best achieved "if the nurse takes the order of the physician as the proper way to determine treatment for the patient (rather than determining treatment herself)" (May, 224-25). Hence physician authority is a rational authority – dependent on the physician's relevant knowledge that compels action, based on the physician's medical credentials. The justification for compliance lies in the purpose of the rational authority.

4.1.2 Second-Order Reasoning

Secondly, May discovers that a rational authority's directive acts as a second-order reason, thereby replacing one's independent deliberation that would otherwise enable a decision (224). Joseph Raz explains this notion of a second-order reason with the example of Ann, "who is looking for a good way to invest her money" (May, 224). In the example, after a taxing and stressful day at work, Ann receives a call from a friend who tells her about an appealing yet time restricted opportunity for investment. The investment is also complicated and Ann worries about the risk involved. Though she would usually be capable of disseminating the risk before the offer is withdrawn, Ann feels too tired and upset to trust her judgement. Knowing that refusing to consider the investment is tantamount to rejecting it, she chooses to reject the offer – not because she believes it to be a bad investment, but because she does not believe she is fit to make the judgement.

May explains that Ann employed second-order reasoning to make her decision, as her action is not determined by her independent evaluation of reasons (224). Instead, Ann's decision was determined by her state of mind, which discouraged her from acting on her evaluation of reasons (May, 224). In this way Ann's state of mind acts as "a second-order reason...[to disregard] what would normally be her reasons for action" (May, 224). Similarly in the health context, May claims that the nurse's lack of

medical training along with the physician's credentials of having medical training serve as a second order reason to comply with the physician's directive (225).

To summarize, rational authority is the authority conferred upon individuals based on reasons for action. This means that rational authority is conferred upon individuals for the fulfillment of some purpose, such that the individuals with rational authority are best positioned to make the decisions that will fulfill that purpose. In the health care system rational authority is usually conferred on the basis of medical credentials, as these credentials render one best positioned to improve patient health. While physician directives directly fulfill the health care system's purpose to improve patient health, nurses indirectly fulfill this purpose by deferring to the physician directives. May labels this process as second order reasoning – withholding acting on one's independent evaluation of reasons for the sake of achieving an overarching goal.

The concept of second order reasoning is highly significant to IPC as it may suggest that, even when nurses merely follow physician directives, they engage in a planning process about patient health. This interpretation would build the case for my recommendation outlined in Chapter Three, that nurses be recognized as plan-makers in IPC decisions about patient health. In the following sections, I argue that a plan-making role is necessary in order to attribute responsibility to members of a collective. As a result, it is necessary to understand nurses as plan-makers when deferring to physician directives, as a plan-taking explanation of nurse deference to physician rational authority fails to account for nurse's responsibility for patient outcomes.

4.2 Hierarchy Responsibility and Competing Duties

4.2.1 Authority and Responsibility

One reason to resist the claim that nurse compliance with physician directives represents a plan taking role is that deferring to authority is commonly understood as a way to absolve one's self from

responsibility. For Isaacs this notion is important as a way to recognize that "organizational action might result when people are simply performing their roles...[without] any big picture commitment to the overall goals of the collective" (30-1). Rejecting the notion that collective action within an organization must involve a commitment to a shared goal, she claims that less is needed to produce collective action. This is because structural authorities such as policies, procedures, mission, and role definition, produce intentional action in these settings (Isaacs, 31).

To illustrate, Isaacs considers people in organizational settings who do not individually make organizational decisions and are not invested in the purpose of the organization, yet still further the goals of the organization insofar as they carry out their roles (31). This includes employees who are alienated from the collective goals, who are primarily focused on their pay, or primarily focused on their enjoyment "exercising specific skills required by job" (Isaacs, 31). In these cases organizations' intentional structures are distinct from the intentions of the individuals performing their functions within those structures (Isaacs, 31). This means that the responsibility attributed to the organization does not necessarily translate into individual responsibility. As a result it would seem that, for nurses, relinquishing authority can be beneficial in a collective setting as it allows one assume less responsibility for outcomes in patient care. Meanwhile physicians agree to assume more responsibility for patient care as they are able to assume more authority over decision-making.

4.2.2 Overwhelming Responsibility

Still, nurses who relinquish authority do so as the result of second order reasoning, in an attempt to fulfill an organizational purpose. Conceptually, this means that they constrain their individual preferences in order to carry out organizational intentions. On the individual level, nurses assume no responsibility for outcomes of patient health. This is because they relinquish the influence of their individual intentions on their actions – instead carrying out the individual intentions of others. Yet on the collective level, the

65

action of relinquishing professional authority is motivated by an intention to fulfill the organizational purpose of improving patient health. This motivation differentiates nurses from the cases Isaacs' discusses where employees are exempt from responsibility when they relinquish authority – as they are alienated from the collective goals

As such, deferring to physicians on the basis of rational authority is not met with complete reduction of responsibility for nurses' actions. In fact, it could be speculated that it is this disparity between the nurses' limited control over their individual actions and the responsibility they nonetheless assume at the collective level that causes moral distress. By complying with physician directives that are clearly mistaken, nurses may become "conscious of the morally appropriate action a situation requires but cannot carry out that action because of institutionalized obstacles" (Corely et al, 382).

In spite of this, there ought to be some difference in the degree of responsibility assumed by nurses and physicians. Isaacs supports this notion by claiming that "authority conferred on individuals by the formal structures of an organization makes some individuals more responsible than others" (98). After all, people who are in authoritative roles make important or essential organizational decisions that can determine collective goals or actions. Individuals with executive authority can merit so much responsibility that Isaacs claims it is possible for key decision-makers to be held individually responsible for collective wrongdoing. She cites Larry May in his discussion of crimes against humanity who describes examining positions of authority as a first step to condemning individuals in a collective wrong. He explains that "one way of holding individuals responsible for group wrongs is to establish that as a collective entity, such as a state, is responsible, and then turn our attention to the individuals who play the most significant role(s) in the collective structure" (Isaacs, 105).

4.2.3 Authorizing Duty and the Competing Role of Nurses

Thus the notion that nurses assume responsibility for obeying physician directives ought to be reconciled with the need to attribute more responsibility to physicians for making key decisions about patient health.

One way to accomplish this is to acknowledge that authoritative decisions are not made on a completely individualistic basis, as individuals are reliant upon the organization to empower them to a position of authority. In these situations, empowerment is understood in the causal sense, where the actions committed by the individual would not be possible without authorization from the organization. "We look to leaders not because their acts are the acts of the organization, but because the organization empowers them to act in ways that they would not be able but for their roles in the structure" (Isaacs, 99). Hence, some responsibility still ought to be attributed to the "authority structures in organizations [which] authorize individual human agents to act on behalf of the organization" (Isaacs, 97).

Interestingly, along with compliance to physician directives, this notion of nurse authorization is an important aspect of the physician-nurse relationship. This is because the nurse' obligation to implement a physician's orders is contingent upon there being no good medical reason not to do so (May, 223). This understanding of rational authority, such that second order reasoning can be used as a means to authorize others to make an executive decision, presents a tangible way in which nurses are central to patient care as plan-makers. In addition to the engagement with the health care system's organizational goals and mandates involved in forming a second order reason, choosing to use second order reasoning requires further engagement with the nature of the directive itself. This is because second order reasoning involves affirming that there are no good medical reasons not to comply to the directive – thus authorizing that physician into a position of rational authority.

By placing responsibility upon the nurse not to comply with some physician directives, nurses are held accountable for their second-order reasoning. Yet this responsibility also places competing obligations upon the nurse and leaves open the question of how judgements about compliance ought to be made (May, 232). Indeed, May reports ambiguous expectations among nurse supervisors and colleagues who believe that patient welfare ought to be the primary goal among nurses, yet recognise the detriments

of questioning leadership (224). Among nursing supervisors, these expectations ranged "from a belief that the nurse should just do as told, to a belief that the nurse should not implement a directive with which she does not entirely concur" (May, 223-4). Meanwhile physicians expect nurses to question their directives, yet only in regards to minor mistakes "such as decimal points being misplaced" (May, 224). With regard to responsibilities to check and authorize physician directives, however, they are more cautious (May, 224).

These competing demands are further muddled by the increased responsibility of nurses to formulate directives. As physicians have come to rely upon nurse as a "full colleague in the provision of health care... including... responsibilities to... diagnos[e] and assess... treatments" (May, 223), nurses such as acute care nurse practitioners and physician assistants have credentials which sometimes enable them to improve patient health independently of physician directives. More generally, nursing staff are becoming more responsible for informing physicians on the patients' cases, thus influencing the health of their patients to a greater degree. For instance, nurses conduct the initial admission interviews with the patient, identify symptoms, and identify complications and changes in the condition of the patient – thus providing all the information that determines both diagnosis and treatment (May, 223). Further the scope of 'nursing orders' is rapidly increasing, meaning that nurses can formulate their own directives for other nursing staff (May, 223).

In summary, hierarchy is meant to clarify the degree of authority and responsibility of workers, where assuming authority increases one's responsibility and merely complying with authority decreases one's responsibility. Whereas hierarchy is usually a healthy part of organizational life it presents problems in the health care system, where complying with physician directives does not fully alleviate responsibility from nurses. If nursing duties are understood as an obligation to comply with physician directives, their degree of responsibility can be seen as unjust. Yet, understood to have a role which authorizes directives, nurses can be seen as highly central and essential to physician directives – and thus

68

highly responsible for patient outcomes. This analysis then presents the problem of hierarchy as one of competing nursing duties – one to be compliant to physician directives and one to check and refuse mistaken directives. To resolve the issue of competing nurse duties, I will clarify nurses' primary duty. Further, it will provide some advice to define the limits of physician authority in a health care hierarchy.

4.3 The Critically Evaluative Nurse

4.3.1 Administrative and Legal Reasons

It is clear that the competing duties of nurses to comply with physician directives whilst checking and challenging mistakes in those directives are both considered to be highly important values among nursing supervisors. While the best interests of the patient should be prioritized, these interests often require efficient decision-making – which may necessitate a division of labour. Yet the nursing duty to check and refuse compliance with physician directives that are clearly mistaken ought to trump their duty to obey directives. May argues nurses have a duty to critically examine physician directives because there is already an administrative and legal expectation that the "nurse who is implementing a particular order is qualified to evaluate whether or not the order falls within an acceptable 'range'" (226).

Administratively, licencing to carry out particular directives is dependent upon nursing education, which trains one to identify highly problematic directives orders. May maintains that nursing education is designed to overlap with medical education such that it enables the nurse "to understand a physician's order and the effects which will result from various treatments" (226). Further nurses require credentials in order to comply with certain physician directives. For instance some licenced practical nurses (LPNs) have the credentials such that they can administer drugs, while other LPNs do not and are therefore prohibited. Similarly, some LPNs have fewer credentials than registered nurses (RNs), and are prohibited from performing RN tasks (May, 226). This dependence of complying to orders upon adequate education suggests that critically examining physician directives is a fundamental aspect of nursing. In other words

69

"if a nurse is not qualified to make... a judgement [on the physician directive], he/she should not implement the directive" (May, 226).

This administrative stance on understanding and evaluating directives is also replicable in law. May references Norton v Argonaut Insurance Co, a case where an infant died of an accidental overdose and her parents sued for wrongful death (226). As a result, "not only was the physician found negligent, but the nurse was also found negligent for attempting to administer a drug with which she was unfamiliar" (May, 226). Here, despite merely using second-order reasoning when carrying out the mistaken directive, the nurse's failure to reject the directive amounted to a neglect of her professional responsibility. Unable to critically evaluate the directive, the nurses' lack of training and lack of familiarity with the drug in question rendered her unqualified to meet the minimum requirements of her position.

This understanding of nurse credentials as a minimum standard for being able to carry out evaluative duties on physician directives challenges the initial portrayal of hierarchy as a barrier to decentralizing authority in IPC. Although hierarchy compels deference to physician authority, such deference is contingent upon nurses approving the directives to be appropriate and relevant to the physician's medical credentials. Due to administrative and legal evidence that the health care system expects nurses to be able to understand and critically evaluate physician directives, nurses evaluative duties are recognized to have a practical effect upon patient care. To some degree this recognition decentralizes the distribution of authority from physicians to nurses as, even where nurses act as plan-takers, they still hold authority over the legitimacy of the physician's plan.

4.3.2 Better Suited to Interprofessional Collaboration

This understanding of hierarchy as a potential way to decentralize authority in interprofessional collaboration is beneficial, as it may result in measure to improve teamwork, such as a better quality of communication. Currently, evidence from Beales et al suggests that nurses are viewed by their IPC teams as inessential plan-takers, thus discouraging the frequency and quality of contributions to the team. In

their study, Beales et al report that low participation rates in IPC activities correlated with a task oriented involvement in patient care consisting of "clarifying, obtaining or accepting physician orders" (338). A nurse manager confirmed their finding, claiming that a lack of involvement in interprofessional rounds limits the nurse from making meaningful contributions to care plans (Beales et al, 339).

Despite encouragement for their attendance, Beales et al found that nursing attempts to contribute to meetings was met with intimidation and professional exclusion (339). This was reflected in the organization of the presentations. The way presentations were organized forced nurses to individually approach teams of physicians and allied professions. In one case, nurses singularly entered the meeting room to already an already seated group of medical professionals; while in another, nurses sat along the back wall of the room and were individually called to sit at a table of medical professionals (Beales et al, 339). This meeting format indicated that continued nurse feedback was not expected or welcomed, and that their role was merely to relay information.

Interestingly, each nurse did not only limit their contributions to relaying information, but kept the presentation of information "to a minimum...[often standing] for the duration of the presentation" (Beales et al, 339). A nurse manager confided that these minimalist presentations resulted from nurses being asked to present on the spot, quickly reporting vitals from handwritten scrap sheets (Beales et al, 339). Meanwhile demonstrations of nurse leadership in meetings were met with resentment from medical staff. A senior physician attributed this resentment to having their authority challenged: "when nursing leads the discussion, medicine feels they are not in control" (Beales et al, 339). Yet, were nurses to be understood in terms of their duty to check and authorize physician directives, contributions might not be taken as insubordination but feedback from colleagues. Corley et al found that nurses who prioritized patient care above duties of compliance were more likely to be involved in dilemma resolution (388). This is because nurses who engage in evaluative duties embrace "raising and discussing difficult patient care issues and problems with ethical implications" (Corley et al found, 388).

71

4.4 Situating Current Hierarchy in the Analysis

4.4.1 CIDS and Collective Essentiality

The interpretation of health care hierarchy as a rational authority reveals some compatibility to the analysis conducted in Chapter Three. In this section, I intend to explain the compatibility between a rational authority conception of hierarchy and corporate internal decision structure (CIDS) as a conception of an organizational collective. Yet these compatibilities are contingent on prioritizing nurse evaluative duties. This is because the prioritization of duties of compliance does not take into account the limits of rational authority. I then argue that the limits of rational authority can be better understood in IPC be promoting care ethics as a core value in IPC culture.

One example is that rational authority affirms the corporate internal decision structure (CIDS) as a useful framework to understand the intentions and responsibility of individuals who further and organizational goal. After all, decisions under a rational authority serve as a nice example of an individual using a decision-structure to serve an organizational goal. To French, an intention is corporate when it "results from the proper functioning of the corporation's CID structure... [often involving] a conjunction of actions of various individual members" (French and Surber, 77). Similarly, the individual efforts among physicians and nurses to improve patient health become a collective organizational effort when they determine their actions using a decision structure. While physicians approach the goal by assessing the best treatment and formulating a directive, nurses (rather than separately assessing the best treatment) defer to the physicians medical training and focus on understanding and checking and complying with the directives.

The nature of rational authority also reveals that nurses are highly central to the overall goal of patient care. Unlike a supreme executive authority, rational authority is dependent upon one's knowledge, training and credentials being essential to the organizational purpose. This means that where it is clear that a physician's directive is mistaken or makes decisions on matters outside their trained expertise, they

cease to hold authority. This makes nurses central to delivering patient care insofar that they critically evaluate the directives of the physician. Meanwhile, physicians cannot assume full individual responsibility for patient care, as they rely upon the authorization of nurses to verify that there directive is, in fact, correct before complying with it. This is to the extent that nurses who are not sufficiently trained to understand and evaluate certain kinds of physician directives are underqualified to comply with them.

May reasons that requirements to understand and critically evaluate physician directives are rooted in a limitation of physician authority. This is that appeals to rational authority must reflect a reason to obey the directive, such that the directive fulfills the purpose of complying with the directive. May illustrates this with an example, where a physician orders a drug to be administered to a patient in a dosage that will kill them. If the nurse understands the implications of the directive, then the directive loses its normative force, as "the directive clearly violates the very purpose for appealing to the physician's judgement" (May, 225). This limitation is also applicable to the physician's mental state. In cases where physician is influenced by alcohol, for example, their judgement would unlikely reflect their medical training – thus undermining the purpose of complying to the physician's directive (May, 225). Physician authority exercised outside these limitations provides no second order reason to obey their directive, rendering nurses obligated to reject the directive.

Further, a hierarchy based on rational authority renders nurses essential because the credentials which grant authority over decision-making processes are not exclusive to physicians. Nurses such as ACNPs and PAs have the medical training and credentials which enable them to diagnose and assess treatments, and formulate 'nurse orders'. By integrating more nurses into roles of rational authority, nurses have a greater role in the planning process – thus enabling nurses to take on more plan-maker roles rather than being summarily dismissed as plan-takers. Thus, in some ways, current hierarchy in health-care is highly compatible with concepts discussed in the past chapter. In particular, rational authority

73

involves the use of CIDS to achieve a collective action, and the reliance of medical authority upon professional training and credentials allow for nurses to play a more central role.

4.4.2 The Problem of Unwarranted Physician Authority

Yet these benefits that a rational authority interpretation of hierarchy confers upon the current analysis are contingent upon the prioritization of nurses' evaluative duties. This is because the prioritization of nurse compliance ignores the limits of rational authority. May finds that physician authority is primarily limited by their basis of authority. In other words "the physician's directive... must be relevant to the particular reasons for which the nurse appeals to the authority of the physician" (May, 225). Thus since nurses appeal to physicians for their scientific and medical credentials in order to improve patient health, only directives related to the medical scientific aspects of patient health ought to be complied with. May exemplifies with the non-medical directive to provide a patient with a television, arguing that it "draws no normative force from the reason to appeal to the physician for determination of action" (225).

While unquestioned compliance to physician authority is sometimes inappropriate when unrelated to scientific or medical directives, it is highly problematic in the context of interprofessional collaborative teams. Where active contribution among nurses is perceived as a challenge by medical residents, nurses take on a limited task-oriented role in IPC meetings. Yet discouraging nurses from participating in IPC, especially nurses qualified to diagnose and treat illnesses, physicians ignore the even more stringent limitations of their authority. After all, the setting of IPC interprets the goal of patient care as being furthered with better teamwork in addition to medical training and credentials. This means that rational authority is not only attributed based on medical credentials, but also the unique approaches to patient care that such training provides. Where physicians refuse to acknowledge the rational authority gained through nurses' diverse approaches to health care, they therefore act based on unwarranted physician authority.

As opposed to rational authority, this unwarranted physician authority is grounded in the physician's professional status and does not rely upon the training and credentials relevant to patient care. Thus nurses in the IPC environments studied by Corley et al are expected to remain compliant even though "there is no reason [pertaining to patient health] to accept the physicians's directive as a second order reason for determining what to do" (May, 225). In other words, nurses are expected to accept physician directives "as a second order reason just because he/she is a physician" (May, 225). Under this professional authority, expertise is instead reverence while compliance becomes professional exclusion and marginalization.

Hence, maintaining nurse compliance to physician directives as a primary duty is a harmful form of hierarchy – relying on unwarranted physician authority in the IPC settings. This is because failing to recognize the limitations of this authority can exclude nurses from the plan-making process and being part of the interprofessional collaborative team. In this way, the benefits of rational authority as health care hierarchy are highly contingent upon the prioritization of evaluative duties above duties of compliance.

4.4.3 Core Values and Rational Authority

One change to the current health care hierarchy that can improve the balance of rational authority between physician and nurses in IPC, is the recognition of nursing core values as relevant to patient care. In his analysis, May recognizes that rational authority is mostly understood in terms of strictly to rigorous scientific training. Still, he contemplates extending rational authority to nurses when it comes to patient care and emotional well-being. Admitting that "the nurses' role goes well beyond that of medicine", May claims that the care and emotion work learned through their education make nurses better qualified than physicians to make decisions about the patient's emotional welfare (225). In addition to increasing the degree of nurses' rational authority, integrating care ethic values as a relevant part of patient care can

garner more respect for nurses' credentials and education. Such respect for the softer aspects of nurse training can encourage more contributions and opinions from nurses engaged in IPC.

A practical measure that can help establish relationship-focused care ethic values as part of medical culture is the establishment of experienced nurses in a leadership role. Corley et al report that experienced nurses recognized their interpersonal experience and knowledge of their patients and were more likely to challenge directives they believed were mistaken (388). They find that "being able to push the boundaries reflects empowerment for nurses and is more likely to occur with increased knowledge and experience" (Corley et al, 388). Interestingly nurses who critically evaluate physician directives using care ethics were more engaged and involved in IPC. For instance, nurses with a greater "autonomy and organizational influence, were more likely to be involved in ethical dilemma resolution" (Corley et al, 388). This involvement also improved job satisfaction as "organizational practices that support raising and discussing difficult patient care issues and problems with ethical implications contribute to perceptions of ethical climate" (Corley et al, 388).

The ability of experienced nurses to challenge unwarranted physician authority while complying with rational authority renders them a great role model who can encourage junior nurses to communicate with physicians. Beales et al found that, in the context of IPC, nurse leadership vastly improved the quality of nurse contributions. In one hospital a rotating nurse liaison facilitated interprofessional meetings in order to "mitigate the junior nurses' feelings of intimidation" (Beales et al, 339). In contrast to other hospitals, participating nurses were more willing to contribute to meetings and were "observed to forthrightly engage with other professionals (e.g. 'anything to relate to me?' 'so, what's the plan?')" (Beales et al, 339). In addition to encouraging more contributions from nurses, the nurse liaison changed the format of the meeting such that the "first request that medical and allied professionals provide updates to the nurse" (Beales et al, 339). Hence, including care ethics as part of the core values of IPC culture gives nurses a rational authority over relational aspects of patient care. Improving the extent of

experienced nurse leadership is an effective practical measure to include care ethics as a core value, as it would encourage junior nurses raise concerns surrounding care ethics values.

4.5 Summary

In summary, the hierarchy which currently exists between physicians and nurses provides a nice framework that can foster the changes that would make the nurse more central to patient care. We understand such a hierarchy to be based on rational authority, which is grounded in physicians' medical training and credentials. Meanwhile, when carrying out physician directives, nurses use second order reasoning to achieve their goal of improving patient health. Acknowledging that the physician's training better places them to assess the correct treatment plan, nurses choose to forgo their own assessments of the best treatment plan and instead choose to focus their efforts on implementing the physician's directive.

Such rational authority seems problematic. After all, deferring authority to physicians is not met with any reduction in responsibility. Yet an integral part of rational authority is the assurance that the directive is correct and relevant to the physician's medical training. Nurses therefore have the obligation to understand and evaluate the order for its legitimacy before carrying it out. While it may seem that this aspect of the nurse's obligation would create competing duties among nurses, there is already the implicit administrative and legal expectation that evaluative duties ought to precede duties to obey.

Theoretically, prioritizing evaluative duties above duties to obey under a rational authority can be beneficial, as it allows nurses to gain more essentiality and improves nurse communication in IPC. This compatibility is contingent upon prioritizing evaluative duties, as this recognizes the limits of rational authority – physicians cannot order directives that are inappropriate, or irrelevant to their medical credentials. In addition to these evaluative duties, a rational authority model can provide nurses with a more central role in patient care as nurses have rational authority over the relational aspects of patient

care. This is achieved by including care ethics as a core values as a core value guiding the health care

system's professional culture

Conclusion

Overall Summarization

In conclusion, applying collective responsibility theory to the issue of health care inequalities between physicians and nurses yields useful practical recommendations that might improve the quality of interprofessional collaboration (IPC), resulting in improved nurse job satisfaction and patient health. My analysis reveals that the exclusion of nurses from IPC can be resolved by reflecting the centrality and essentiality of nurses to decisions about patient care in the collective agency of the health care system. This can be accomplished formally, through organizational structure, and informally, through professional culture. In Chapter One, nurse job dissatisfaction and the barrier it poses to patient care is explored as a symptom of inequality between physicians and nurses. This is primarily revealed through the implementation of interprofessional collaboration, an approach to patient care where decision-making about patient health is made by a team of health care professionals. Though it is suggested that building team-work between physicians and nurses improves job satisfaction, power imbalances and disciplinary differences inhibit this work. In light of this critique, transdisciplinary collaboration is proposed as structure of collaboration which would solve such power disparities. Further, collective responsibility theory is suggested as a theoretical framework that can help yield transdisciplinarity.

In Chapter Two, collective agency is explained as a significant concept within collective responsibility theory which can apply to organizations and goal oriented collectives. A collectivist interpretation of collective responsibility theory, one which argues that there is a collective agency which is irreducible to individual agency, is explained and defended. In essence, group actions are governed by group intentions that cannot be captured by an aggregate of individual agencies. This is because group intentions encompass factors such as the joint goals that are subconscious in the minds of individuals, and the shared understanding that each group member stands in relation to other group members in pursuit of a joint goal. Instead, group intentions are intended by a collective agency, which remains ontologically

separate from individual agency. This ontological difference is supported with evidence from the fields of Psychology and Behavioural Economics, Game Theory, and Neuroscience and Evolutionary Theory.

In Chapter Three, the disciplinary inequalities existing between physicians and nurses in IPC are explained in terms of collective agency. Collective agency manifests in the health care system formal organizational decisions, which are made using a corporate internal decision structure (CIDS). Yet collective agency also manifests in the informal decision-making undertook by interprofessional teams - these decisions are governed by the team's core values. The internal decision structures of the health care system challenge nurse initiatives to improve patient health and do not support nurses when they encounter disciplinary conflicts. Concepts of tightness, centrality, and essentiality are applied to determine that these problems result when the internal decision structure portrays nurses as plan-takers rather than plan-makers. In addition to these formal problems, the professional environment in health care renders nurses less essential by stifling nurses from giving input into decision-making. This is because the core values which govern group culture do not incorporate nursing values, such as relational care ethics.

At first glance, however, these measures to render nurses more central to patient care and achieve transdisciplinarity in health care collaboration runs counter to the hierarchical structure which currently characterizes the health care system. In Chapter Four, a rational authority model of health care hierarchy is explained in order to reconcile hierarchy with these initiatives. Under a rational authority model of health care hierarchy, nurses use second order reasoning by deferring to those with appropriate medical credentials in order to achieve their goal of improving patient health. This model of hierarchy seems problematic to achieving transdisciplinary IPC. Yet the provision that nurses ought to assure that the directive is correct and relevant to the physician's medical training allows nurses more opportunity to raise concerns and input their own suggestions to improve patient health.

80

Solutions and Speculations

By explaining health care IPC in terms of collective agency, this inquiry reveals that there are many facets of inequality between physicians and nurses inherent to the organizational structure, professional culture, and the widespread misunderstanding of hierarchy in health care. As such, achieving transdisciplinarity in health care requires the development of a diverse range of solutions to address these different facets. Some required changes are more formal in nature, and directly affect the distribution of authority in IPC. These include modifications to hospital policy in order to clarify the job descriptions of hospital staff and render nurses more central to decisions about patient health by portraying them in a plan-making role.

I speculate that a key aspect of these changes to policy guiding IPC is the avoidance of language suggesting that nurses in IPC are supervised by the physicians. A common description of nurses who take on a central planning role, such as acute care nurse practitioners (ACNPs) and physician assistants (PAs), is that they form their directives under the supervision of a physician. Such supervision may be a necessary aspect of these particular jobs, but I believe this dynamic should not carry through into formal IPC teamwork. This is because nurse contribution to IPC will perceived as an extension of the physician's contributions and will therefore not be recognized as an independent disciplinary perspective. Instead IPC policy should associate nurse involvement in a central planning role with the context of the IPC team.

Achieving transdisciplinary in health care IPC also requires the implementation of initiatives to change the professional culture such that nurse contributions are valued by the rest of the IPC team. Some of these initiatives ought to focus upon education – changes to the curricula of schools of medicine and nursing, as well as the implementation of continued professional training to improve teamwork. Meanwhile other initiatives focus upon the accessibility of services, such as ethics committees, which can help facilitate nurse perspectives on moral decision-making. In this way, the softer skills of nursing would be valued in making decisions regarding the interpersonal aspects of patient health.

I think that a beneficial way to make these changes to organizational policy and professional culture is to apply a rational authority model of hierarchy. For instance, in clarifying the job descriptions of physicians and nurses, the limits of physician rational authority and nurse evaluative duties could be speculated. This would include nurse challenges to physician directives as part of the health care system's formal internal decision structure.

In addition, rendering nurse values more central to the health care system's professional culture can affect the distribution of authority under the rational authority model by giving nurses a rational authority over the interpersonal, relational aspects of patient care. This can be achieved by improving the prevalence of experienced nurse leadership in IPC teams. Experienced nurses, who are found to challenge problematic physician directives and to encourage junior nurses to communicate in interprofessional groups, demonstrate the importance of nurse relational values to decisions about patient health. In addition, they act as role models and moderators – allowing nursing students to express their professional opinions in an environment where they feel valued.

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