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9. THE DISCOURSE ON ETHICS AND EXPERTISE IN PROFESSIONAL PRACTICE

"Because real expertise is never entirely separable from a community of practice, it is never fully purified of social and moral engagement."
(Sullivan, 2005, p. 255)

Professions have a long history of an ethical or public-serving purpose. Professionals, unlike businesses, pledge to protect fellow human beings in vulnerable states (Sullivan, 2005; Pellegrino & Thomasma, 1993). However, one of the criticisms of professions throughout the twentieth century has been the emphasis placed on the internal professional, technical and specialty expertise (Sullivan, 2005), rather than external engagement and purpose in relation to clients and the community. The Carnegie Foundation's Preparation for the Professions Program, a comparative study across clergy, law, engineering, medicine and nursing, found a strong emphasis in university-based education, on two types of professional learning apprenticeships for the development of professional expertise. The first was education in analytical reasoning and thinking skills to learn profession-specific knowledge base, and the second was skills-based apprenticeship in discipline-based practice (Colby & Sullivan, 2008). In contrast, apprenticeship to ethical standards and responsibilities of the profession was found to be comparatively neglected and a more marginal aspect of professional education. This third apprenticeship is the subject of this chapter.

Verkerk and Lindemann (2012) posit that ethical reflection and practice is not an add-on to professional skills, but is integral to and effected through the public, professional, and personal norms and values within practice. However, we live in a relentless, market-driven time where the contemporary context of professional work poses challenges to professionals in terms of retaining this integrated ethos of doing "good work" (Gardner, Csikszentmihalyi, & Damon, 2001; Colby & Sullivan, 2008). Changes to funding and organisational models of public services (e.g. healthcare) also alter the profit/care dynamic (Emanuel, 2014; Sullivan, 2005). Increasing choice of service providers and practitioners and the explosion of information and critique about professional services (e.g. healthcare) via the Internet has shifted the practitioner/client relationship from one of automatic trust in a practitioner's authority and beneficence to a more critical consumer-oriented interaction.

How might the future of professional practice be shaped by consumerism in the practice world?

J. Higgs and F. Trede (Eds.), Professional Practice Discourse Marginalia, 73-82.

Our chapter explores the critical interdependence between ethical and professional, technical expertise of professionals, and how this relationship might act as an important buffer to counter forces which strain or act to dilute the essence of "expert" professional practice. We argue that expertise encompasses virtues or traits which intrinsically guide ethical reasoning and practice. We also highlight that despite being an embedded component of expert practice, as Sullivan (2005) notes, acting ethically requires both preparation and ongoing commitment of practitioners, who, in addition to being technically competent, have the reflective capability and motivation to continue to learn and develop expertise which is imbued with professional ethical values and literacy. Colby and Sullivan (2008) draw on the Carnegie research and suggest five key conditions for nurturing positive ethical behaviour and high standards of quality professional work.

1. Deep engagement with the profession's public purposes where intrinsic sense of meaning and satisfaction from professional work aligns with extrinsic and public-oriented purposes
2. A strong professional identity
3. Development of habits of salience whereby complex situations are understood or framed, at least in part, in moral terms
4. Development of habitual patterns of behavioural responses to clients, authorities and peers that are aligned with the profession's standards and ideals, not self-interest
5. Development of the capacity to contribute to the ethical quality of the profession with a sense of moral agency, moral imagination and courage to create more constructive practices.

Our key contention in this chapter is that integrating these features of professional work into everyday decisions and actions, requires specific skills which include considering and describing relevant moral considerations, explicating moral concepts, and detecting discipline-based theoretical commitments. For example, where cases or problems are referred to professionals for their expert opinion, traditional expectations are that they bring their professional discipline-specific reasoning skills to the content of the problems. However in contemporary expert practice, we suggest they also have an obligation to perceive relevant moral dimensions of the problem (see Wear & Kuczewski, 2004). In addition, they need an awareness of the boundaries of their practice which reflects the scope and nature of their disciplinary theories and commitments, how these commitments impact on their clients' problems and how they differ and/or integrate with other professionals in the best interests of their client. We suggest these skills require deliberate nurturing to ensure practitioners continue to discern moral issues in changing and morally complex practice landscapes. We first describe the key features of both ethics and professional expertise and then analyse how they might inform each other to enhance practitioners' capacities to integrate the ethical with the professional practical and technical aspects of practice.

How has globalisation influenced the moral complexity issues faced by professional practitioners?

Ethics Expertise

A formal notion of ethics expertise, as it applies to professional practice settings, involves a "thorough knowledge of moral propositions and ethical theories, and the skills to use this knowledge in a professional way" (Steinkamp, Gordijn, & ten Have, 2008, p. 174). "Good practice" requires practitioners to first know about and then absorb professional moral norms and principles. Practitioners then apply these norms and principles to the human condition and client needs as these emerge in professional decisions, relationships with clients and colleagues, and during negotiations around different values, interests and opinions in practice situations. Dreyfus and Dreyfus (2004) suggest that acting ethically is a type of skill which is attained alongside the development of professional expertise, over five stages (novice, advanced beginner, competent performer, proficient performer and expert). For example, novice health practitioners in the early stages of skill acquisition rely on straightforward rules about presentation of signs and symptoms, pathophysiology or, from an ethics perspective, notions of beneficence and non-maleficence. As they progress through their training and encounter more practical clinical experiences, they discover, or have identified by their discipline-specific supervisor, new features of situations. Specific rules become more general maxims to follow depending on the features of a client's situation and circumstances. As situations become more complex, practitioners must begin to move away from maxims, to a more agentic approach, where they begin to take responsibility for developing their own plans and responses and for making choices about the right thing to do to achieve a particular outcome. Over time, the practitioner learns from these choices and uses their experience and feedback about the outcomes of their actions, to inform their future responses. As moral agents, they absorb the professional ethical norms of practice including recognising moral dimensions of their work and making judgements about the right thing to do for their clients. They develop an internalised ability to deal intuitively with moral questions and problems.

One reading of this progression towards professional and ethical expertise is that over time, practitioners will generally develop ethical expertise through their experience in encountering, responding to and noticing outcomes. However, as Bereiter and Scardamalia (1993) highlight, expertise is not a state or status that is passively achieved but it is a dynamic and ongoing process of professional development requiring motivation to continue learning and improving. Experts have been shown to build extensive and well-organised practical knowledge through the use of strong self-monitoring or meta-cognitive skills (Ericsson, Charness, Feltovich, & Hoffman, 2006). These reflective skills are a foundational element in their professional reasoning process and they are manifest in skills of careful listening, so as to integrate the lived experience of the client with foundational and more formal professional knowledge (Benner, 1984, 2000; Edwards, Jones, Carr, & Jensen, 2004; Schön, 1987).

Does the increased external scrutiny posed by 21st century accountability challenge the essential self-appraisal expectations of professionals?

Benner similarly argues in the caring or helping professions, ethical reasoning cannot be separated from professional reasoning because good professional judgements reflect good professional practice (Benner, Tanner, & Chesla, 1999; Benner, Sutphen, Leonard, & Day, 2010). In the caring professions, human interactions and care are central aspects of the work which means the professional reasoning process cannot have a singular focus on a process of analytical, deductive, or rational thinking (Edwards & Delany, 2008). The focus of care in the social services is a much larger process that extends beyond the identification of a diagnosis and is iterative and ongoing. Knowing a client, understanding his or her story, fitting the client's story with professional knowledge, and collaborating with the client to problem solve the way forward are integral components of ethical reasoning. Practitioners who engage in "good professional practice" are grounded in a moral commitment and professional duty to helping clients during periods of vulnerability (Benner, 2000; Pellegrino & Thomasma, 1993).

Interesting to see the growing role and value of stories in practice service arenas – particularly as they sit alongside evidence-based and cost-limited service expectations.

Professional Expertise

Professional expertise has been studied extensively to highlight its salient features and developmental processes in professional practice (Dreyfus & Dreyfus, 1996, 2004; Benner, 1984; Ericsson, Charness, Feltovich, & Hoffman, 2006). Much of this research has focused on describing expert performance and comparing how novices versus experts respond to a professional situation. We know that novices are more rule-governed, like to rely on others for guidance, have a hard time seeing the entire situation or context and are quick to apply an intervention based on what they (currently) know rather than what the particular client in a specific circumstance requires. In contrast, experts take account of the entire situation. They are comfortable with uncertainty and seek to understand the context of the situation through intense listening to the client. Experts are highly motivated and engage in deliberate practice to continue to learn and improve. They have fluent retrieval of their knowledge not because they have better memories but because they organise their knowledge around core concepts which makes retrieval easier (Dreyfus & Dreyfus, 1996, 2004; Benner, 1984; Ericsson, Charness, Feltovich, & Hoffman, 2006).

These descriptions capture essential features of expertise, however they portray expertise as somewhat automatic and effortless and they do not help to differentiate the impact of experience on the development of expertise. Bereiter and Scardamalia (1993) argue that non-experts may well have experience but are comfortable with routine practice while experts problematise what appears to be routine practices. Experts work hard, take on complex cases or activities and set standards for themselves that are often just beyond their reach. Experts seek activities that maximise their opportunity for growth whereas non-experts are comfortable with routine practice.

In a grounded theory study of expert practice in physical therapy (Jensen, Gwyer, Shepard, & Hack, 2000; Jensen, Gwyer, Hack, & Shepard, 2007), the investigators proposed that expertise in physical therapy is some combination of multidimensional knowledge, clinical reasoning skills, skilled movement, and virtue, where all four of these dimensions come together as the clinician's philosophy of practice. Consistent with other research in expertise (Benner, Tanner, & Chesla, 1999; Ericsson, Charness, Feltovich, & Hoffman, 2006), knowledge was multidimensional and client-centred, and therapists drew from several sources for this knowledge including specialty knowledge, professional knowledge gained through reflection on practice and listening carefully to their clients. Virtue was an important core dimension of expertise and seen in practitioners' behaviours such as care and compassion for clients, non-judgemental approaches to clients, admitting mistakes, and taking deliberate actions such as reporting unethical behaviours of colleagues or serving as an advocate or moral agent for clients. In a ten-year follow-up study, these same experts had all engaged in continued learning, ranging from seeking advanced degrees to engagement in professional research. Ethical distress was a daily occurrence and a point of frustration, yet they were not complicit, depressed or apathetic but actively engaged in serving as moral agents in helping clients and families receive the physical therapy care they needed (Jensen, Gwyer, Shepard, & Hack, 2007). This and other research highlights an important element in professional expertise; a practitioner's ability to integrate the capacity to make professional judgements in uncertain conditions with decisions based on moral agency where deliberate action can benefit and/or minimise harm for clients and families (Delany, Edwards, Jensen, & Skinner, 2010; Sullivan, 2005).

These studies demonstrate that the ethical dimension is an essential foundation for professional expertise. They also suggest that while this dimension of professional work is complex, multidimensional and sometimes tacitly recognised and practised, it is nevertheless visible through practitioners' motivation and their drive to continue to learn and develop as excellent practitioners (Stichter, 2011). To progress through the five stages of expertise, Dreyfus (2004) suggests a need for perseverance or motivation to continually improve and to maintain a commitment to high standards pertaining to what counts as the right thing to do. This, in turn, raises the question of how to educate for, or nurture, the motivation necessary to continue to integrate and sustain both professional and ethical components of expertise.

Sustaining Moral Expertise within Professional Expertise

At the beginning of this chapter, we suggested that practising ethically requires deliberate nurturing to ensure practitioners continue to discern moral issues in changing practice landscapes. Nurturing professional expertise is a well-established and expected approach to maintaining currency of practice, and ensuring professional care is evidence-based and competent. Where a professional problem is particularly complex, an expert practitioner will use a

more structured and deductive approach to solve a professional problem (Edwards, Jones, Carr, & Jensen, 2004).

We argue that as practitioners encounter more complex and diverse ethical dimensions of their professional practice, they need a deliberate and structured approach to discern moral issues, consider and describe relevant moral considerations, explicate moral concepts and detect the types of theoretical commitments they are adopting within their professional practice. This includes a capacity to engage in broader collective professional reflection where respect, openness and creativity are used to address moral problems facing individual practitioners and the broader profession (Verkek & Lindemann, 2012; Edwards, Delany, Townsend, & Swisher, 2011a, 2011b).

In the following section we provide two case examples (a student scenario and a professional situation encountered by a more experienced practitioner). These are both drawn from the clinical practice world but similar ethical considerations could be encountered in other fields of professional practice. We use a series of questions from a previously published model of ethical reasoning titled "active engagement" (Delany, Edwards, Jensen, & Skinner, 2010) to foster ethical reasoning in the student and we suggest structured ethical discussion (Delany, 2012) for experienced practitioners to encourage both the novice to begin and the expert to continue to integrate their ethical and professional reasoning skills.

Case 1: Student Story

I was working in the ICU and I entered the room of a 14-year-old patient who had sustained multiple fractures from a suicide attempt. The mother was in the room with him and soon after my clinical instructor and I had arrived the father and stepmother came into the room. After the introductions, I started to conduct my subjective examination but I noticed the mother and father starting to argue. I tried to keep going with my examination but the argument grew louder, and now the stepmother had become involved. The point that made me feel uncomfortable, was the fact that they were blaming each other for what happened to the patient and talked about him like he was not there. The patient just lay there with his eyes barely open watching the argument unfold and began to cry. He could not speak or make any sounds so he was helpless as his father and stepmother attacked his mother and vice versa. What was I supposed to do? I kept trying to do my examination but knew that was not the right thing to do. My clinical instructor was not in the room with me and I felt somewhat helpless.

In the active engagement model, we proposed three overall steps:

1. To *listen* actively
2. To *think* reflexively
3. To *reason* critically.

In telling the story about this 14-year-old patient and his parents, the student is already exhibiting elements of the first step of active listening. She is also demonstrating a commitment to the importance of telling and listening to stories as a way of discussing ethical issues and she is both attentive to and curious about "the details of other people's stories" (Delany, Edwards, Jensen, & Skinner, 2010). To build on this first step of ethical reasoning, educators could encourage the student to progress to thinking reflexively about her own "physical therapy footprint" in the clinical scenario – how she might be perceived within that encounter and what values and theoretical commitments are driving her treatment goals and her apparent moral distress about the situation. This second step requires the student to both recognise but also move away from her emotional reaction, to consider how her knowledge, skills and overall professional presence might be contributing to the ethical challenge. Incorporating the third step of the active engagement model would involve encouraging the student to critically examine the meaning and application of the four established biomedical ethical principles: beneficence, non-maleficence, autonomy and justice in this scenario. What harms is the student concerned about for this patient? What could she do to minimise these harms? What can she say? Whom should she consult? How can she understand the factors contributing to this conflict? To nurture both capacity to engage in this thinking, and motivation to continue to explore and be curious about "good practice" we suggest educators need to acknowledge their students' capacity to identify ethical dimensions of their clinical practice experience and then to explicitly support and scaffold their ethical reasoning by assisting them to further question and discuss options for responding ethically as part of clinical reasoning.

Case 2: Senior Physical Therapist Story

This case concerns a 20-year-old woman with severe cerebral palsy (non-verbal and non-communicative). For the past 18 years, while in a paediatric care setting, she received intensive and regular physical therapy treatment whenever she was admitted to hospital. She now presents in an adult care hospital. Her cardiorespiratory function is rapidly deteriorating. She has had three recent ICU admissions and non-invasive "rescue" therapy has been implemented. The family is insisting on 3-4 physical therapy treatments per day. Several physical therapists and clinicians think the patient should be treated regularly and others think that treatment should be more palliative in focus. This case is told by a senior physical therapy specialist who has worked as head of the cardiorespiratory unit for the past 10 years.

A nurturing ethical expertise response in this situation, requires a less structured education approach and instead of having a supervisor or educator identify explicit ethical reasoning steps to the senior physical therapist, we suggest implementing regular clinical ethics discussion within the physical therapy department or more broadly within the ICU unit, where conflicting views are canvassed, values are expressed and participants have an opportunity

to listen to their colleagues' perspectives (Delany, 2012). The case provides an example of how, senior members of multidisciplinary teams are often required to reconcile differing values held by members of the health team, the patient, their family or carers, and differing or conflicting values about what counts as the ethically appropriate action. The goals of structured ethics discussions are to foster dispositions and practices that enhance collegial relationships ultimately leading to greater recognition of and communication with colleagues and ultimately improvements in clinical care.

Delany (2012) proposes that participation in regular ethics discussions in the form of professional ethics team consultations, has important pedagogical value for ongoing learning and the development of moral agency for practitioners. In particular, participating in dialogue where differing views and perspectives are shared, creates opportunities to deepen self-understanding, and to reflect on common sense assumptions that typically frame daily decisions and practices.

CONCLUSION

In this chapter, we have presented the arguments that good professional practice requires knowledge, skill, character and the courage to act and that ethics is a key not peripheral component of professional expertise. See Figure 9.1.

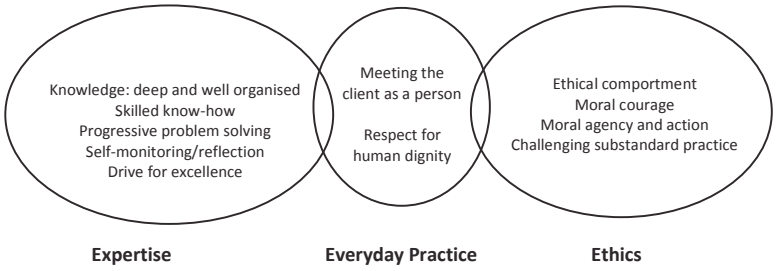

Figure 9.1. Ethics and expertise: The nexus

It is not uncommon that institutional contexts, influenced by market concerns and productivity demands, challenge professionals and their ability to integrate their professional and ethical foci. This means that educators must consider how to prepare students for high quality and complex professional practice that represents both expertise and ethical competence and practitioners must continue to strive for improvement in both ethical and professional reasoning. Bereiter and Scardamalia (1993) have demonstrated that it takes a deep commitment to the aims and methods of the practitioner's profession to facilitate students on the path of continued learning which includes both professional and ethical dimensions. We suggest that to address the challenge of moving the "third (ethical) apprenticeship" from the margins of professional practice to a more central place in professional responsibility and practice,

educators and mentors need to be intentional and committed to nurturing ethical expertise (Edwards, Delany, Townsend, & Swisher, 2011a, 2011b). Our case examples provide suggestions for this more explicit nurturing of students and practitioners to develop and continue to practise the ethical reasoning steps of analysing and responding to ethically troubling situations.

We close this chapter by referring once again to the key concept that real expertise (professional and ethical) cannot be separated or marginalised from a community of practice that includes not only social engagement but moral engagement (Figure 9.1). The development and integration of the third apprenticeship is a non-negotiable component for novice development and continued development of expertise.

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