ETHICAL CHALLENGES OF THE FUTURE FOR THE NURSING PROFESSION

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After the publication of *Health for All in the 21st Century* by the World Health Organisation in 1999, many articles and books on healthcare ethics began to raise the issue about the future direction of the nursing profession. Though some authors claimed that the role of nursing and midwifery in the health care systems of the twenty-first century would definitely preserve many features of the past, others argued that today's dramatic changes and rapid developments, globalisation, technological advancement and demographic changes would create inevitably future challenges and opportunities.

During the first two years of the new millennium, literature on bioethics continued to intensify the discussion on the changing future agenda of healthcare systems. Many predict that the future will force healthcare professionals to go through regular, radical changes in their job requirements. It is claimed that healthcare professionals have to emerge from their task-oriented past and to take on work that requires them to think, judge and intervene. To stay within established paradigms is to become further enmeshed in problems of a system that is really no system at all. Instead, healthcare professionals must create their own future lest they become irrelevant in a future others have made for them.

In Malta, nursing and midwifery are now well-established healthcare professions, having a place among the respected professions, with a university-based education. Health professionals in nursing and midwifery should not only look with satisfaction at past achievements and present accomplishments, they also must courageously challenge the present system, skills, attitudes and mentalities in order to prepare

themselves more adequately for the future. They must never be afraid to raise such questions: What should be the ambitions of nursing and midwifery in the twenty-first century? Have the professional goals that nursing and midwifery been moving towards become now less appropriate? Do they need to be redefined? What changes and new skills are required in order to remain relevant for the healthcare system of tomorrow?

The phenomena of change and development call for the formulation of new policies. In the attempt to be always contemporary and relevant, to address the extraordinary challenges presented by new developments, there is the risk that one fails to address the ordinary routine and ethical problems that all nurses and midwifes must face. Life is characterised by both continuity and change, and while addressing the challenges of present and future change, one must keep in mind that certain features of human life do not change. For example the processes and problems, pleasures and suffering related to birth, nutrition, adulthood, reproduction, parenting, maintenance of physical and mental health, ageing and death apply to all human beings, past, present and future.

While individuals may change, for good or ill, it is questionable whether human nature changes. In fact, the problem of making sense of living, of pain and suffering, facing death and bereavement, and the meaning of happiness will remain, whatever advances are made in medicine and human sciences. The role of nurses and midwifes in providing professional care and emotional and spiritual support to people in times of personal crisis around some of the most critical 'life events' is probably something that will never change, although the resources and skills available at different times and in different places will undoubtedly change.

1. High-tech health care and holistic care

Advances in biotechnology are having a spectacular impact on prevention, diagnosis and treatment of illness. Technology will continue

to increase access to information and education and to create new and expanded roles and skills for nurses and midwifes.

High-tech health care does not only offer immense opportunities for both patients and healthcare providers, but also risks and challenges. In modern times, impersonal, technical developments abound, and consequently, the human dimension of medicine has come under considerable pressure. New technologies separate healthcare professionals from their patients in subtle ways.

Healthcare is a form of human encounter characterised by help. Whatever the healthcare professional does for the sick person involves, by definition, a certain closeness or relationship. High-tech medicine is threatening this encounter. Technology-minded healthcare professionals are dreaming of a medical care devoid of relationship, and based entirely upon data provided by sophisticated machines and computers. This view influences every aspect of high-tech medical care. In a technical, medical utopia, sophisticated error-free tests linked with medical computer programmes would eliminate the personal relationship between the healthcarer and patient entirely, and it is claimed, improve the delivery of health care.

High-tech healthcare should not be a substitute for the humanising touch of healthcare professionals. Nurses and midwifes will require more and more skills in technology assessment and confidence to use advanced technology to enhance quality of care and information exchange. However, there will be a need to balance the high-tech with the human aspects of caring and compassion. The technological environment of our healthcare systems should never lead to the depersonalisation and dehumanisation of the patients.

The focus of healthcare professionals should remain on care rather on control and power. A shift is required from a "paradigm of control" to a "paradigm of relationship". Nurses and midwifes have to detach themselves from a "position of observation and rational explanations" to a focus on relationship. They must interact more intimately with the patient as a human being.

The view of 'medicine as technology' should never substitute the view of 'medicine as an art'. Medicine remains an 'art' when care remains at its centre. The word 'caring' is derived from the Latin term *carus* (dear), designating something that is valued or expensive because it is scarce. By derivation it came to mean loved, desired or esteemed because of the intrinsic value of the object of care. Through Christian influence, caring expresses unconditional love or selfless concern for physical, emotional and spiritual well-being. The healthcare professional should avoid succumbing to the "magic" of technology by acquiring those character traits which ensure a 'caring and healing relationship' rather than a 'technological relationship' with the patient. To care for the patient means to be compassionate, competent, conscientious, committed and confident.

2. Globalisation and Interdependence

Globalisation will continue to have an impact on the economic, political and social aspects of life. The opening up of the world trade and free movement of ideas, capital and people across borders will raise challenges and opportunities for nurses. It will enhance standardisation, international credentials, easy access to information and nursing networking.

Globalisation will also raise concerns about disease transmission through trade, travel and migration, as national boundaries become obsolete and people, services and goods move freely across boundaries. At the same time globalisation will facilitate a move towards a "universal culture" and easy transfer of knowledge and skills.

The local debate on Malta's application to become a member of the European Union is to be seen from the perspective of globalisation and interdependence. It is the conviction of Malta's Government that in today's globalised and interdependent world, our country should not remain isolated and segregated from the rest of the world. Malta's

membership to the European Union will enhance its national identity and at the same time open up unique opportunities that would be missed by remaining out of the EU.

What opportunities and challenges are offered by EU membership to nurses and midwifes? Many students following courses in healthcare profession are already benefiting from EU programmes in education and training in other European countries. One of the EU requirements to qualify as a nurse to work in other countries is adequate knowledge of the science on which general nursing is based and also of ethics of the profession and the general principles of health and nursing. Opportunities of education and experience of work in clinical setting in other European countries will definitely increase the standard and enhance the experience and skills of our healthcare professionals. These opportunities are an immense investment in the human resources of our healthcare system.

Nurses and midwifes working in other European cultural settings will face eventually the challenge of getting involved in clinical situations that bring in conflict their own ethical values. Should a nurse or midwife participate in an abortion? Is it ethically permissibly to get involved in clinical decisions that will lead to active voluntary euthanasia? Many European countries have legislation on a number of medical and biotechnological issues. Are healthcare professions morally obligated to follow these legislations? All codes of ethics for healthcare professionals endorse explicitly a clause that safeguards the healthcarer's right to conscientious objection. When nurses and midwifes get involved in clinical setting in which their moral and ethical values are at stake, they have the right to refuse to participate in that medical procedure on the ground of conscientious objection. The fact that European countries have legalised abortion or voluntary euthanasia is definitely not a valid argument for our healthcare professionals to refrain from exposing themselves to other clinical settings. The challenge to uphold sound ethical values should not preclude nurses and midwifes from immense future opportunities offered by membership to the EU.

3. Public expectations

Though the health care profession still enjoys respect and confidence, doctors, nurses and other health care providers can no longer claim to have uncontested authority on their patients. The general public has become more critical of the behaviour of those who care for them during their stay in hospitals. Patients are becoming more demanding, expect more information, more attention to holistic care, quality of care, and active participation.

The increasing number of lawsuits against healthcare professionals in Malta indicates that the general public is becoming more and more vigilant and conscious of malpractice in healthcare. In the United States, healthcare professionals are hesitant to touch a patient because they are afraid of ending in the law courts. Such situations, which definitely increase anxiety and pressure on all healthcare professionals as well as diminish their freedom in clinical settings, present a challenge to all healthcare professionals to be more vigilant of their responsibilities and professional duties. When nurses and midwifes find themselves involved in a legal litigation against colleagues, their first allegiance is to the patient rather to healtheare professional colleagues.

The nursing profession requires today more than ever before a greater level of competence in communication skills, a greater sense of honesty and responsibility. Since the public is becoming better informed and more assertive about health services, professional decisions are sometimes challenged. Patient groups are increasingly negotiating with professionals about the care they want. In the future the public will expect better and more convenient access to health care, more information and more attention to holistic care. At the same time, concerns with human rights, equity, accountability and ethical issues will come to the forefront of debate and action.

In the future, nurses and midwifes will be expected to take more and more the roles of patient's facilitator, patient's advocate and whistleblower. In adopting the approach of patient's facilitator, the nurse

seeks to enhance the autonomy of the patient or client. This role lies within the client-centred and educational approaches that invite the participation of individuals. As a facilitator, the nurse should enact her/his role with warmth and empathy, building confidence, sharing skills and knowledge and encouraging the individual to enter into a relationship of trust and openness.

In the exercise of their professional accountability, nurses and midwifes are expected to accept the role as an advocate on behalf of her/his patients. Advocacy is concerned with promoting and safeguarding the well-being and interests of patients and clients. Nurses deal with human rights issues daily, in all aspects of their professional life. They have an obligation to safeguard people's rights at all times and in all places. There is a need for increased vigilance and a requirement to be well informed about how new technology and experimentation can violate human rights. The application of human rights protection should emphasise vulnerable groups such as women, children, elderly, refugees and stigmatised groups. A commitment to protect human rights includes assuring that adequate care is provided within the resources available and in accordance with nursing ethics. The nurse is obliged to ensure that patients receive appropriate information prior to consenting to treatment or procedures, including participation in research.

Whistleblowers are people who draw the attention of the public to negligence, abuses or dangers, such as professional misconduct or incompetence, which exist in the organisation in which they work. The decision to blow the whistle on a colleague is never as easy one; unless there is a legal obligation to report, it should be considered a step one takes when all else has failed. In health care institutions, threats to patient safety may come from prescribed treatments, environmental hazards, staffing inadequacies, or illegal, incompetent or unethical conduct of any employee or person.

Do nurses have the right to blow the whistle? Some authors claim that in some situations there is a moral obligation to disclose harms.

4. Changing demographics

The twenty-first century has been termed the age of ageing because it witnessed a revolution in longevity. The average life expectancy has increased by 20 years since 1950 to 66 years, and is expected to increase a further 10 years by 2050. Every month, a million persons in the world turn 60 years of age. The number of persons over 60 years will increase from 600 million to almost 2,000 million by 2050.The oldest old (80 years and over) are the fastest growing segment of the population. Indeed, by 2050, for the first time in history, the number of older persons in the world will exceed the number of young. This phenomenon has already occurred in the developed world by 1992. These demographic trends which every country is undergoing, are having social, economic and political effects on society and on its institutions such as the family, social and health services.

Today, the dominant medical ideology is to provide a cure, and thereby contribute to the prolongation of life. However, given the increase in the number of elderly people beset by chronic and non-chronic illness, the objective of medicine can no longer be solely that of curing. As far as the elderly are concerned, medicine can, and should, have new aims that are not so much to do with the number of years people live but with the quality of their lives. While an increase in the elderly will challenge healthcare delivery, nursing actions in wellness clinics and homes will enhance positive health and healthy ageing so that older people will lead active and productive lives with minimum disability.

In the future, healthcare systems will invest more and more in geriatric care. More health carers will be involved with the care for the elderly. As a consequence, healthcare professionals will have to face more issues in geriatric ethics: when is it morally permissible or even mandatory to withhold or withdraw life-sustaining treatment to an elderly patient? Who should decide when the elderly is incompetent? By what criteria should decisions be taken? Is quality-of-life a valid criterion in issues of life-supporting treatment? Is old age a valid criterion in the allocation of scare medical resources?

Healthcare professionals should never discriminate against the elderly because of old age. Ageism is wrong. The Declaration on Ethical Issues on Ageing, presented by the Government of Malta to the Second World Assembly on Ageing organised by the United Nations in Madrid, Spain, on April 2002, states explicitly that the use of language about older persons, in particular, by the young, by those professionals whose work brings them in contact with older persons, and by the media deserves serious consideration so as to ensure objectivity and respect.

5. Scarcity of medical resources

Maintaining a healthcare system in the face of ageing societies, constant and usually expensive technological developments, and ever-rising public demand is proving difficult. A new model of health care is needed, what is called a 'sustainable' model. By that I mean a model that is affordable over the long run'– indefinitely into the future – and that is equitably available to all. Rationing will be necessary in any and all future health care systems. No system, however efficiently managed, is likely to be able to keep up with the constant stream of new and expensive technologies, most of them offering only marginal improvements over those that have gone before. And none will be able to cope through managerial techniques with the combination of ageing societies and technological innovation.

The current model of healthcare features a commitment to constant medical progress, assuming that progress is an indispensable good. This model aims at the conquest of all diseases, one disease at a time. It seeks an indefinite increase in average life expectancy. Such a model has helped to engender a number of characteristic biases in the provision of healthcare. There is a bias towards cure rather than care, another towards length of life rather than quality of life, still another toward technological interventions rather than health promotion and disease prevention.

On the contrary, a sustainable model of healthcare would start with a more limited idea of progress, not an open-ended one. It would have

finite, achievable goals, beginning with the goal of helping people to avoid a premature death, not death itself. It would have a different set of biases. It would accept death as an inevitable part of the human condition just as it would understand that not all suffering can be eliminated. It would understand that some degree of dependency is a necessary feature of life together in community, just as it would understand the necessity of setting limits and rationing healthcare. If everyone is to have access to a decent level of care, not everyone can have access to the most optimal care.

The problem is that individualism is itself the major obstacle to an affordable, sustainable medicine. A healthcare system dominated by individualism has no good way of saying no to individual needs, however much they may hurt the common good. It takes all rationing and all limits as an offence to human dignity. Respect for the rights of the patient is based on human dignity. However, human dignity can be achieved and protected only in solidarity with others. The essence of a common-good approach to ethics is that the individual is never seen as existing separate from the community. The individual has freedoms, rights and privacy that must be respected, but he or she also has responsibilities to others.

The sick individual is not only a patient with rights but also a citizen with duties. The patient is an individual-in-community. The dominant social value of Western society focuses on the freedom and rights of the individual and gives less recognition to community obligations. Without undermining the importance of individual rights, the tradition can be modified to recognise the ethical importance of solidarity, relationships, and commitment to common goals and to meeting the needs of others.

Individualism plays too strong a role in the area of treatment decision making, frequently to the exclusion of any other consideration. An individual has a legitimate claim only to a fair share of healthcare resources, not to every treatment that might well be beneficial. There are economic and ethical limits in providing all and every possible

medical intervention. Using a common-good or community-based ethic as a framework for treatment decision making may provide appropriate balance to the emphasis on patient desires. Everyone has a legitimate claim to a basic level of healthcare. On the other hand, no one has a legitimate claim to treatment that is being withheld as part of a just rationing system. A just healthcare system is one in which individual desires for medical treatment beyond the basic level are accommodated whenever possible but not when they undermine the primary purpose of medicine to meet the basic healthcare needs of all persons.

In the future, governments will continue to search for cost-effective ways to increase access to health care, and the trend is towards shorter hospital stays, reduced staff and early discharge of patients. In this environment, nursing's potential and competencies in areas such as home- and community-based care, team leadership, budgeting, supervision, negotiations and entrepreneurship would flourish. Increasing professional autonomy and the expanded nursing role in which nurses function in areas previously performed by physicians will be a dominant trend in the future, according to the 1998 Royal College of Nursing.

Future healthcare reforms will continue to provide nurses with new career prospects in preventive, promotive, curative and rehabilitative services and opens up avenues for nurse-led practices in such areas as specialised clinics, cancer care, etc. Nurses involved in health promotion will have to present a clear message to the general public: take care of yourself and do not count on medicine to save you from yourself.

6. Partners of care-planning process

The emergence of quality improvement movements in healthcare has resulted in two major changes in patient care. It has broken down barriers between hospital departments and reshaped systems for patient's benefit. Traditionally, nurses have been co-ordinators of care.

In a case management model, nurses become true collaborators in the patients' care process. They no longer simply take orders, but actively participate in designing a plan of care.

Collaborative case management is a multidisciplinary approach to patient care. It involves the development of "clinical pathways", plans of care for a single diagnosis as directed by a specific physician or group of physicians. From a certain pathway, an organised care'"map" (multidisciplinary action plan) is developed and individualised to meet the needs of each patient. In developing these plans, the nurse works directly with the physician and personnel from all other hospital departments involved in patient care, such as radiology, laboratory, pharmacy, quality management, food and nutrition, home care and pastoral care. As relationships mature, everyone involved begins to speak the same language and to learn more about the role various disciplines play in patient care. In this process, what was once a "nursing care plan" now becomes a "patient care plan".

In addition to breaking down departmental barriers, collaborative case management also removes barriers between physicians and nurses. While nurses have always co-ordinated the care for the patient, they now become partners in initiating the care and setting goals for the patient. One key to this partnership is that everyone has access to all the information relevant to the patient care process. Good communication is critical to effectively implement this system.

Collaborative case management has many advantages, including maximised quality, improved efficiency, increased patient satisfaction and enhanced collaborative team practice. But the major advantage of the process is that it puts the patient at the centre of health activity. By gathering and co-ordinating input from all personnel involved in patient care, the procedures are attuned to the clients' genuine needs. By making the patients more aware of their treatment plan, they become true collaborators in the care process.

7. Enhancing 'teamwork' spirit in health care

Few people, with the exception of a small number of self-employed practitioners, work on their own. Most people in their working lives are employed in institutions of some kind and have to learn to work together, and make decisions together, with other people in teams. These teams would, almost by necessity, comprise people with a variety of professional background and expertise. This diversity, like that of a football, is not only the basis of the strength of the team, but also a potential source of weakness. Our power is enhanced by participation in teams; we can do more together by co-operation, pooling our resources and a sensible division of labour.

However, lack of trust, non-co-operation, confusion of roles, and inability to share power effectively can be a disaster. For a smooth and efficient functioning of a hospital, nursing, paramedical and administrative, technical and service staff, there has to be some clear division of labour, with a clearly understood hierarchy of power and authority, roles and responsibilities.

Research in teamwork in health care settings suggests that doctors, nurses, paramedics and administrative staff are generally ill-prepared to work in teams with other professionals – segregated as they are from one another in basic training. Put another way, many professionals are trained as 'soloists' rather than as players in a symphony orchestra, and are ill-equipped or inexperienced in sharing power and responsibility.

All medical practitioners have one primary goal, namely to ensure measurable and positive outcomes of their medical treatment. With this commonality in mind, it is crucial that an interdisciplinary teamwork should be aimed at in order to provide optimal care for the patient.

Studies show that the quality of healthcare professionals' relationship affects the outcomes of care. Quality of care and teamwork are

inseparable. Good teamwork aims to produce a better outcome for patients and to make each team member feel valued and fulfilled. Effective interdisciplinary teams can enhance the efforts of quality improvement. Unfortunately, when teamwork is not functioning optimally, patient may have a less satisfying experience, leaving them with little confidence in the process. Without a team approach and good communication throughout, a favourable patient outcome is jeopardised. Harmful health care often happens as a result of no communication or a breakdown in communication between several providers who may or may not be from different disciplines or between providers and patients.

All health professionals have the same overriding goal, namely the restoration and/or maintenance of their patients' health. This calls for a co-ordinated effort from all of them. The input of team members can influence the treatment plan. There are two characteristics which the members of health-care teams should consistently display: first, solidarity with and mutual respect for one another, and secondly, a willingness to co-operate with one another for the good of patients. Where these characteristics are absent, the well-being of patients may be put at risk.

Membership of a well functioning team – one with clear team and individual goals, that meets together regularly, and that values the diverse skills of its members – reduces stress levels and increases performance. Thus coherent teamwork is crucial for the delivery of good quality patient care both directly in terms of efficient and effective services, and indirectly via its effects on reducing stress. Teams need to be aware of all the responsibilities of a unit, with knowledge of each other's work, developed ways of working together and supporting each other.

Concluding remarks

Nursing is at present at a crossroad in its development. It is a relatively young, fast-growing academic discipline and comprises an occupational

group numerically larger than any other in health care. It has a legacy of being in a subordinate relationship to a dominant medical profession. However, nurses are developing a sense of identity and confidence of their own. This is based not only on 150 years or more of accumulated experience of nursing, but also on more secure knowledge arising from the application of the methods of the behaviour and social sciences to nursing research. All this adds further impetus to the desire of nurses to articulate the unique insights they can bring to health care, and to develop a body of knowledge and area of practice for nursing which they can claim as their own.

Nurses and their associations must show vision, strength and strategy if they are to pass on a strong, socially relevant, vocationally satisfying profession to the future generations of nurses and citizens. Now is the time to reflect on accomplishments, learn from failures and decide what direction to take in the next millennium to further advance nursing, nurses and health.

We must support the dynamic evolution of nursing practice in facing today's changes and challenges and to ensure quality health services. Nurses must respond creatively to present challenges in shaping a vital future. They need to re-educate and redefine themselves professionally. They need to prepare themselves for vital roles in outpatient care, home healthcare, and community-care. Nurses' need for a more varied and complete education will pose a challenge to academic institutions. Our Health Care Institute will have to respond quickly to new demands by creating a curriculum that prepares students for more challenging clinical and managerial responsibilities. The education system also will have to develop courses that enhance nurses' flexibility, improve their decision-making skills, and familiarise them with the profession's basic values.

In the twenty-first century, nurses will have to tap what, historically, has been one of their greatest strengths – their adaptability. They will have to stretch everything – their power, their knowledge, their influence – to remain relevant to the healthcare system of tomorrow. This is a challenge not to be missed!