

Summary

Dilemmas of nurses and carers

*"I do think many people immediately think about things like euthanasia when ethics is mentioned", says a carer working in home care. "But how we treat clients is also about ethics. You run into moral dilemmas every day if you look at it that way. The question is whether nurses and carers recognise these dilemmas."*¹

Moral dilemmas in daily care

Ethics, nursing and caring are inseparably linked. Unsurprising, as providing good care is, at its core, a moral practice. The essence is doing well, not harming, acting respectfully and not discriminating between people. Nurses and carers want to provide good care. They want to give patients and clients the care they need, and want to distribute care in a fair way. That is their moral ideal of care. Providing care is impossible without facing moral dilemmas, as it is not always clear what the right or best choice is. Like the carer quoted above states: nurses and carers regularly come face to face with moral dilemmas as part of their work: dilemmas that address both traditional ethical issues, such as euthanasia, and everyday caring activities.

Moral distress through changes in healthcare

In recent years, nurses and carers have been increasingly confronted with (moral) dilemmas, dilemmas caused by recent changes to healthcare, such as new legislation, new financial structures, greater public accountability and tasks shifting between care providers. These dilemmas are best described as moral distress; you know what good care is, but you feel powerless, hampered or unable to put this care into practice. This powerlessness to do good causes people to experience moral dilemmas.

These 'moral dilemmas' are different from (traditional) moral dilemmas that address the question: '*what* is good care in this situation?'. These dilemmas are more strongly related to the question: '*how* do I enable good care in this situation?' It is additional tasks and requirements are that lead to these types of dilemmas. Consider institutional requirements, such as achieving targets, meeting performance requirements and dealing with new financial structures, such as ZZPs (care severity packages) and DBCs (diagnosis-treatment combinations). These changes make nurses and carers feel overwhelmed by additional tasks, which take time away from providing good care.

¹

Carer statement during CEG inventory round, May 2009.

Changes that most affect nurses and carers

GOOD CARE FOR MINOR INDICATIONS

The indicated care remotely determined by the independent CIZ employee frequently does not meet the care requirements. Carers and nurses are frequently faced with this situation: they know the patient, client or resident well, they see what care is required, but cannot provide it fully. Unsurprisingly, nurses and carers say this is their most pressing concern. They are regularly faced with the dilemma of what to do: act on their own professional standards for quality care, or only provide indicated care?

LOYALTY RELATED TO UNDERSTAFFING

Second and third place are held by dilemmas associated with understaffing in healthcare: a lack of financial means, lack of personnel, understaffing and subsequent frequent use of poorly qualified personnel. Appeals are also often made to care provider loyalty. A third of the interviewed care providers indicate that they deal with this on a weekly basis. They are asked to work overtime due to understaffing. 42% are troubled by this problem. Being asked to come to work on a day off is another issue carers and nurses (49%) find difficult to cope with. These are the dilemmas that should be addressed first.

DIFFERENT DILEMMAS IN DIFFERENT CARE SECTORS

Both the Centre for Ethics and Health (CEG) and the Netherlands Institute for Healthcare Research (NIVEL) made an inventory of the dilemmas associated with recent changes in healthcare in three sectors – hospital care, care in nursing homes, and home care. There is common ground, but there are also a number of differences. Specific dilemmas faced in hospitals include differing views between nurses and doctors on patient treatment, diagnostic testing and hospital discharge. Nursing and care homes, on the other hand, are most concerned about care indications: getting the required care organised, even if it does not correspond to the care indicated by CIZ. This leads to dilemmas like: 'can I give a client a little less time than indicated, so I can spend that time on another client?' and 'may I have a client request more care than required in order to obtain the right care indication?' The underlying question remains: 'How can I provide good care in this situation?'

Sources of moral distress

Moral distress consists of feelings of powerlessness, subordination and inefficiency, but also leads to passivity and blunted moral sensitivity. These feelings were frequently mentioned when we asked about daily moral dilemmas during both the CEG meetings and the NIVEL postal survey. They are caused by increased external pressure that appears impossible to resist. Carers and nursing staff feel overwhelmed by changes in healthcare that do not visibly improve the quality of care. 'Cutting costs' seems to them to be the only motivation. This conflicts with the motives that carers and nurses have for entering the field, and erodes their intrinsic motivation. It also leads to unacceptable deterioration and fracturing of care, a low trust social environment, and an inevitable draining away of quality personnel and influx of (too) poorly qualified workers. The deterioration of

healthcare becomes a very personal issue, and leads to general sense of moral unease and a lack of motivation.

Moral issues are not recognised, poorly addressed and discussed

In daily practice, moral issues are often ignored, and neither identified or discussed. What was learned in nursing school is quickly forgotten in practice. Dealing with moral issues is not solely a personal issue ('me and my conscience'), but also a social one. If ethical issues are never discussed, a care provider needs to have strong convictions to raise them anyway. Carers and nurses are generally shy in this respect. A sense of having reached the limits of acceptable care could also lead to a great moral debate. The lack of such a debate appears to be caused by a lack of professional self-respect. This creates a vicious cycle: lacking appreciation leads to care impoverishment and a hollowing out of the profession, which leads to low self-respect, which in turn leads to more lack of appreciation. And lack of appreciation in turn contributes to staffing shortages.

Solutions and good practices

Since many of these problems are not new, and are widespread, solutions are being sought and a number of initiatives have been developed. Some of the issues are related to the way healthcare is organised, and a shift in this area has been noticed. For example, the announced changes to the way in which certain Exceptional Medical Expenses Act (AWBZ) care indications are determined, returning part of the responsibility to the care provider. Other problems are caused by the fact that, due to a lack of time and funding people do not have the opportunity to 'deal with ethics', despite the clear desire to do so. However, initiatives including moral discussions, medical ethics meetings or organisational structures that leave room for everyday moral issues have been launched. Some have also pointed out that nurse and carer attitudes need to change as well. They will need to expand their professionalism, and stand up for the responsible and necessary care they believe in.

Giving and taking professional space

In order to prevent or diminish dilemmas and moral distress, nurses and carers need to take a stronger position. This requires efforts from their environment, but above all from themselves. It is a give-and-take situation: nurses and carers need to be given the space to take responsibility and use their professional insights. They know the resident/client/patient better than anyone else involved in the care process, and know exactly what care is required. On the other hand, they also need to 'take' the required space: nurses and carers can demand this room to act, position themselves more proactively, and not allow themselves to be pushed out of their professional role by systems or external demands.

The government can – and recently has begun to – ensure through policy initiatives that nurses and carers are given more space to take professional responsibility and provide care as they see fit. The training of nurses and carers can play a part by providing new

forms of ethics education suitable for each specific functional level. Institutions need to be more fully aware of day-to-day dilemmas faced by front-line care providers, and accept the associated responsibilities. Interest groups and professional nursing and carer organisations are the linchpins in this process, and can represent the professional group at political and government levels. They can also support professionals with good practices. Managers need to be the first to pick up and address any dilemmas faced. They are (jointly) responsible for maintaining a healthy balance between quality care and corporate efficiency. Finally, nurses and carers will need to take up a strong, confident position and trust their professional insights when fighting for the quality care they so dearly want to give patients, clients and residents.