THE MANAGEMENT OF NURSING CARE

FUNDACIÓ
VÍCTOR
GRÍFOLS
i LUCAS

Monographs of the Víctor Grífols i Lucas Foundation
THE MANAGEMENT OF NURSING CARE - No. 12 (2006)

Published by: the Víctor Grífols i Lucas Foundation
c/. Jesús i Maria, 6 - 08022 Barcelona

Translated by A&G Translations

Printed by: Gráficas Gispert, S.A. - La Bisbal
Depósito Legal: GI-904-1999

CONTENTS

INTRODUCTION

In this seminar we will discuss the relationship between two extremely important issues: how care is managed, and the ethical aspects of care. Within this context, we will consider the specific contribution nurses make to the provision of health care. During the last few decades, nurses have made significant advances in their understanding of both the meaning and the ethical scope of care, and we have defined an 'ethics of caring'. According to this ethics of caring there is an ethical dimension which is intrinsic to the act of caring, and this enriches the discourse of health ethics and helps to inform it with the perspective of the service users, patients and family members who receive care.

The way in which nurses care for people entails notions of what needs to be done and how it needs to be done, and is of paramount importance if we really wish to ensure that our care model focuses on the client, patient or service user. When organizing a health service, the basic principles of professional care should at the very least be given the same weight as the basic principles of treating illness. At the same time, we also need to understand that applying bioethics and respecting human rights requires far-reaching changes to our healthcare culture, both at the level of health professionals and their relationships with colleagues and service users, and in the way that services are organized and managed. However, guidelines and regulations on their own are not enough. We must also change the way we work, identifying the responsibilities which underpin the contribution of each professional group: for example, with regard to ensuring that information is accurate, helping people to understand health problems and alternative courses of treatment, building and maintaining respect and dignity, making sure that family and friends are included in care decisions when appropriate, respecting the privacy of information, handling people gently, respecting their personal space, and so on. It goes without saying that these issues affect nurses just as much as they do other health professionals. This is why we feel it is important to clarify the progress made by our profession in this regard, and inform people about it.

We can see, then, that there are two main ways in which nurses can contribute to ethical issues: within our own discipline, by organizing and attending to people's care needs, and by contributing our knowledge to the work of the care team. With this in mind, it would seem important to reconsider the assumptions which underpin the management of health

services in general and nursing services in particular. We believe that an awareness of ethical issues and the ability to analyze them is vital if nurses are to address such issues in their clinical practice, and this in turn requires both specific education in ethics and an organization which gives due emphasis to these issues.

In this seminar we will debate the relationship between care management models and ethical care, and will consider the question of the responsibility of the care manager with regard to professional ethics. It is clear, then, that we view the issue of ethical care as one which relates to the management and organization of services, not just as an issue for each individual nurse.

In my position as a teacher at the School of Nursing, one of my concerns is with how students can maintain and develop their professional values throughout their career, and how health organizations can support them in doing this. I will therefore end my introduction to this seminar on the "Management of nursing care" with the opinion of a student who, after reading about and considering the importance of ethical approaches to care, wrote the following:

"Having read the article, several ideas occur to me; among others, and perhaps most clearly of all, is the notion that caring and the 'caring presence' are concepts which operate in two directions at once.

In my opinion, to take the example of the administration of medication, the role of the nurse is not merely to follow medical instructions in applying the treatment but is, instead, much more far-reaching and complex. It encompasses providing information about the actions and interactions of the drug, ensuring that patients have all the information they need with regard to the proposed treatment, promoting patient autonomy with regard to their care, ensuring continuity of treatment after discharge if required, and identifying the best pathway for administering the drug in question to the specific patient. And all of this just for the administration of a single drug.

It is clear, then, that in more complex issues such as health education, the care to be delivered will be even more complex because it will need to take into account many aspects of the patient in order to treat him or her as a whole person and ensure that there is a 'caring presence' at all times.

But who looks after the nurses? Who cares for the nurses so that they can look after themselves? I believe that it is important to provide integrated care

for each individual patient and to help create a caring presence, but I do not believe that this can be achieved if the nurse who provides such care is not looked after when she needs it. If every unit is to work to full capacity and deliver the highest quality of care possible, we must promote a working environment which creates a caring presence not only for the patient but also for nurses, and other health professionals and staff, reducing stress and ensuring that the personal resources of carers are not exhausted."

This student's words make very clear the importance of the relationship between the person who provides direct care – that is, the care nurse – and the person who organizes the care – the nurse manager. The feedback between the two is also clear; being a good nurse is the responsibility of every individual health professional, but it also requires nursing management to be focused on helping each health professional to achieve their full potential.

The seminar aimed to:

- consider the contribution of nursing care to health ethics
- identify the relationships between different management models and ethical nursing care.

Montserrat Busquets
Spokesperson for the Board of Trustees of the
Víctor Grífols i Lucas Foundation

FIRST PAPER

THE MANAGEMENT OF NURSING CARE

Mercedes Ferro Montiu

1. Introduction

At times, something from among the welter of everyday experiences to which we are exposed causes us to stop and think, and forces us to ask a question. Not the sort of question which can be easily resolved, but rather one of those questions which force us to reconsider our ideas and reflect carefully upon them, and which, once we have arrived at an answer, also make us aware of the need to reorder other parts of our value systems. It is at such moments in one's professional life, when one is caused to doubt or question a particular idea or concept, that we often also reconsider other ideas which until then had seemed clear. In this way we assimilate new professional paradigms and expand our explicit knowledge of some of the important aspects which underpin our ability to sustain and improve our professional competence.

When I was invited to contribute to this discussion forum on ethics and the management of nursing care, I felt as if I was facing one of those unique moments of reflection. As a nurse with over 20 years experience of management activities, a large part of my professional studies and working experience has been concerned with issues of management responsibility. As a result I felt that I already had clear and well-considered views on these issues. However, the invitation included a commitment to analyze and reflect upon the issues from an ethical viewpoint, and this in turn made it necessary for me to reflect once again upon what management involves, this time through the lens of ethical concepts and values.

In this context I must confess to some feelings of insecurity, and even perhaps a little embarrassment, as I become aware of the clear limitations to the degree to which I apply an ethical approach to my professional duties. As is inevitably the case, my professional role, which basically involves the organization and management of nursing care and nursing professionals, constantly poses questions which have an ethical content, focusing on issues of good or evil, duty, rights, appropriateness, justice, responsibility, costs, autonomy and quality. It is on such occasions that I turn for an answer to what I understand by the concept of an ethical commitment (my values as a person), to other people or, at the organizational level, to institutions or companies.

This period of reflection has been quite challenging, because the questions which have arisen from observing or analyzing my own experience through an ethical lens have made clear the existence of cracks, weak points and questionable behaviours. This exercise has placed me both as an individual and

as a professional in a space where my values and my acts meet, a space where at times the lines are very blurred.

I am absolutely firm in my belief that the meanings of the values or ethical codes surrounding every human action are not an external addition to these actions but rather form an integral part of them. But I have still felt the need to review the actions and significance of managerial responsibility from the perspective of ethical codes. This exercise gave rise to some of the thoughts I share with you below, and brought out some of the conclusions which I have set down here so that they can be exposed to wider debate.

2. The function of the nursing profession in our society. What value does it have to offer?

Before addressing the topic of today's seminar, ***"the management of nursing care"***, it seems appropriate to set out some general ideas regarding the nursing profession. This activity, in so far as it relates to the basic act of caring for people's health, can be considered to be as old as the history of humanity itself. However, while it is true that throughout history and across a whole range of civilizations or societies there is clear evidence of the existence of individuals who, on the basis of their knowledge or skills, took on these responsibilities, it is not until the 19th century that we see organized training aimed at professionalizing the activity of caring. The first schools of nursing were established following the intervention of Florence Nightingale. This was the beginning of the long road which, together with a lot of hard work, has culminated in today's university studies in nursing. As a result of this process, the nursing discipline has come to constitute a body of knowledge which forms the basis of, and underpins good practice in, the profession of caring for people's health.

Last April, the philosopher and writer José Antonio Marina gave a talk[1] in which he argued that, in a deep sense, the notion of the 'person' is an ethical rather than a scientific concept. If I could translate any of the nursing profession's explicit or implicit beliefs into my own practice I would say that it

[1] Humanismo en el arte de cuidar. *XI Congreso Nacional de la Sociedad Española de Enfermería Geriátrica y Gerontológico*. Vitoria, 2004.

is precisely this which should be embodied by every nurse: the belief that being a person is an ethical concept. And this is why I will also echo him in linking the concepts of 'person' or 'patient' to the notion of the human being as someone who is endowed with dignity. Indeed, I can find no better way of describing the central principle of the nursing profession than by quoting the words of Professor Marina: "I would like to emphasize care as being at the very core of what it is to be a person … care is a respectful and perceptive attitude, which captures and protects that which is valuable, which promotes action, which strengthens the bonds between people, which takes serious issues seriously."

Caring for people's health is, therefore, the main aim and objective of the nursing profession. And caring for health has, throughout history, constituted the activity of nursing. This basic activity has been the bedrock of an entire profession, precisely because of the very high value attached to the meaning of human life, health, integrity, dignity and independence, when considered from a holistic and integrated viewpoint of what it means to be human. This is a profession born of the fundamental social necessity for the right to health, and is exercised on the broad basis of caring for individuals, families and the community, drawing on the explicit consideration of the values and beliefs both of carer and patient, in interaction with the wider social context in which they exist. Our profession, therefore, consolidates and draws its legitimacy from providing succour to human beings' most basic needs, be they individuals, families or communities.

The core activities and values of the nursing profession focus on caring for people's health, in whatever circumstances they may find themselves, and throughout their lives. This is the value which the nurse contributes to the society or community in which she is based and, starting from this two-way relationship of need and support, the nursing profession is a guarantor of the health and integrity of society, and society in turn is a guarantor of the profession.

With regard to the relationship between ethics and nursing, Professors Antón and Busquets argue that, "ethics is not something which is tacked on to professional development, but rather it provides the basis of such development and gives it meaning. It is not possible to talk of ethics and nursing as two isolated concepts which are superimposed upon each other."[2]

---

[2] Casado, M. *Materiales de Bioética y Derecho*. Ed. Cedecs. Barcelona, 1996.

This profession, dedicated as it is to caring for people's health, where interpersonal relationships are more than a mere means of communication and become, in many instances, the best treatment method available, has always demonstrated and been exercised on the basis of an ethical commitment. The relationship between nurse and patient is therefore by its very nature an ethical act. In the words of Anne J. Davis: "Nursing has never viewed ethics as a trivial issue or a passing fad. Indeed, ethics has been the real basis of professional nursing practice since the dawn of modern nursing in the 19th century."[3]

I would now like to express my first set of ideas:

The function of the nursing profession within society is that of caring for people's health. And the value which this brings is to help people be born, live and die in whatever circumstances they find themselves, showing the greatest possible respect for their own values. Caring for people's health is, by its very nature, an ethical act.

[3] Anne J. Davis. Las dimensiones éticas del cuidar en enfermería. *Enfermería Clínica*, vol 9, núm 1. p. 21.

3. Some conditioning factors in the health environment. In what context is nursing care provided?

As stated above, the value the nursing profession offers to society is that of caring for people's health, an ordinary form of attention which should be provided throughout people's life and one which becomes extraordinary at given moments such as birth, illness or death. The act of caring and its effects on health are therefore felt in each of the many situations in which people are cared for, and this means that they are conditioned by a wide range of factors which interact at many levels. These conditioning factors occur within the context of a two-way relationship between the provider and the recipient of care, as a result of which some of their effects can grow exponentially.

As Rosa María Alberdi explains, "the nurse's contribution is, anyway, indispensable and irreplaceable, and takes as many forms as there are individuals receiving care."[4] This is why we can describe care as the result of professional action occurring within the context of a specific health care and social setting, and arising from an individualized nurse to patient interpersonal relationship.

In our society, nursing care is overwhelmingly provided by health organizations. Most of the time health services are supplied by multidisciplinary teams which work together to deliver better health outcomes. It is by working through such mixed teams that we offer a unique health product which ultimately translates into the improved health of society as a whole.

The fact that a product or service is delivered by a team should not prevent this outcome from being unique and individualized, and nor should it prevent the establishment of personal relationships. It just means that the organizations or companies which create their products in this way must establish effective coordination mechanisms to ensure that their internal processes constitute a care continuum, where the recipients of care perceive the benefits of each of the individual components of this continuum. The internal coordination of all these processes is therefore absolutely vital to those health organizations which achieve their results through plural, multidisciplinary teams.

---

[4] Alberdi Rosa M. Nosotros cuidamos: la práctica del cuidado en el ámbito comunitario. *III Congreso Asociación Enfermería Comunitaria*. Arnedillo, 2000.

Every organization or company should clearly identify each of its final products, together with the processes on which its activities should focus. When the health product is the result of multidisciplinary team working (and being a single product does not preclude being made up of different parts or inputs), then the sub-products which make up the whole must be very clearly identified. This means that in each health organization (hospital, clinic, service, unit, primary care team, etc.) nursing care is a major or minor part of that whole which is referred to as the health product. This is the view put forward by Rosa María Hernández.[5]

There is no disputing that, in today's health organizations, the care provided by nurses constitutes an indispensable and integral part of the final product or outcome, but while this is easy to understand in theory, it is far more difficult to give this concrete expression in reality. Instead, it is still the case that many of our health organizations restrict the responsibilities and decision-making powers of nursing professionals to a background and merely advisory role when it comes to issues such as care responsibility, planning, and evaluating the health product. Any nurse in the course of performing her duties is constantly aware of the importance of the care she provides in ensuring a positive outcome from any health process, and by the same token we can be confident of the importance of her professional work for the patient's well-being and the quality of care provided. Despite this, health organizations generally give scant recognition to the nursing profession, and what recognition they do give bears little relationship to the significance of nursing care as part of the overall care process.

The views set out above summarize the opinions of many nurses, and in particular their belief that their role in health organizations receives little professional recognition, and that they are granted only limited decision-making powers, professional responsibility and professional autonomy. This situation raises a number of questions. Why does this happen? Should organizations do something to recognize the role and contribution of nursing in care processes and outcomes? Is there anything which nurses themselves should do?

At present the contribution of nursing to the health product is poorly identified, not fully recognized and, as a result, undervalued, although it is also true that efforts are gradually being made to ensure that care is given real,

[5] Rosa M. Hernández La medición del producto enfermero. *Enfermería Clínica*, vol 5, núm. 3 pág. 111.

tangible value. As far back as 1986 Collière developed the concept of "invisible care,"[6] in research which showed the disproportionate and poorly recognized presence of nurses with regard to their actions, results and added value in the care process. However, there is still a long way to go until we have real recognition of the impact of such care on the health product delivered by health organizations. There are studies into the impact of nursing care on health outcomes which show the impact of nursing organizations and nursing actions on the morbidity and mortality of patients. Linda Aiken, referring to the results of studies of so-called 'magnetic hospitals', writes that "the organization of nursing within the overall context of the centre gives nurses a greater degree of independence to structure their practice as they deem fit," and shows how patient mortality rates are reduced in these nursing organizations.

In my opinion, the "health product" has improved greatly in recent years as a result of significant advances in the medical product, and in particular its pharmacological and technological components. This has greatly improved the efficacy and efficiency of diagnostic and therapeutic processes, and has delivered significant reductions in the length of average hospital stays. Now it is both necessary and essential to improve the product yet further through the as yet unexploited channel of nursing decisions and actions. These form the basis of an important component of care quality which is linked to nursing care and whose capacity for improvement has not yet been utilized.

Health care occurs in the social, cultural and health context of each individual, family or community, delivered by multidisciplinary teams working through health organizations.

Those sub-products or parts of the health organization's final product which have been contributed by the nursing profession should be clearly identified and recognized, in accordance with the value which the nursing profession's actions add to the health product.

Within health organizations, nursing professionals should have the level of influence, responsibility and authority which correspond to nursing care on the basis of the added value it contributes to the health product.

---

[6] Collière, M.F. Invisible Care and Invisible Women as Health Care Providers. *Int. Journal of Nursing Studies*, 23 (2) 95-112, 1986.

4. Do nursing organizations meet citizens' expectations?

As the sociologist Carmen Domínguez-Alcón explains, the health sector, "is of particular interest to the sociologist because it reproduces the social structure."[7]

The fact that an organization reproduces a social structure might lead one to assume that it simply replicates the current expectations and needs of citizens, but of course this does not happen immediately. Rather, we can see how the great majority of today's health organizations still embody some structures which are anchored firmly in a past which, however recent, is still part of the past.

Any organization which hopes to maintain and develop its value within the social structure must evolve at the same speed and in the same direction as society as a whole. This also affects nursing organizations, and these must be geared for continuous adaptation, developing the sensibilities and intelligence required so that they can rapidly identify the latest trends in social, cultural, economic, demographic, environmental or political changes within society.

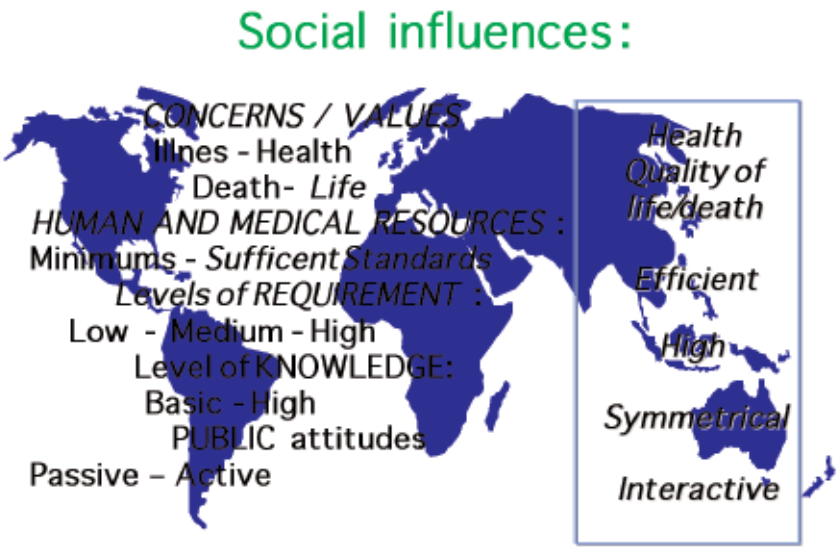
Permanent, adaptive change has been a constant feature of every society throughout history. Today, in addition to this we must take account of two new factors: the speed at which change is now occurring, and the complexity of globalised society in a world without borders. Modern society is characterized by the rapid speed of change and this requires rapid adaptation to changing social and health trends. As a result, nursing organizations must continuously review their knowledge, organizational models, structures, processes and outcomes. This is part of a wider requirement to respond rapidly and continuously to the changing values and needs of the society in which they have their roots, but it should be noted that this response is very expensive for today's health organizations to deliver, particularly given the general rigidity and resistance which they typically display.

One of the strongest influences on care is the context within which it is provided: that is, the social and health setting in which care for people's health is managed and delivered. In order to help to understand what this complex

[7] Carmen Domínguez-Alcón *et al. Sociología y Enfermería.* Ed. Ediciones Pirámide. Madrid, 1983.

process of continuous adaptation involves, I will identify some of the visible or invisible factors which, in my opinion, have had the greatest influence on nursing organizations over the last 25 to 30 years.

- *Values* in regard to the concept of "health" have shifted, in a matter of years, from focusing on illness or death to emphasizing health and life, and in the course of this they have shaped a new social objective: the right to "quality of life and of death" or "the right to live and to die well".
- *The availability of human resources,* of knowledge, materials and technology has advanced so much that we have gone from a situation of scarcity to one in which these resources, while far from unlimited, are generally available. As a result, we are now concerned with ensuring that use of these resources is "efficient" or fair, appropriate and responsible.
- Another factor relates to the *level of expectations* or demands of individuals and of society as a whole. These expectations have risen rapidly in recent years, and will undoubtedly continue to do so in the future.
- In society as a whole, both quantitative and qualitative *information* has gone from being scarce, unevenly distributed and not generally available to society, to being both abundant and freely available. The task remains to ensure that it is distributed more evenly, and that, instead of remaining in the hands of health professionals it is shared with patients, clients and service users.
- The effect of *globalization,* of a world without borders or geographical limits, means that our society is increasingly influenced by a range of diverse cultures. Life in the global village demands that we respect these differences.
- Another factor is that of *citizens' attitudes.* Citizens no longer live in conservative societies, passively accepting whatever is offered. Instead, we are moving towards societies in which they play an increasingly active role, with ever greater levels of real, interactive participation in health organizations of every type.



There is a general consensus surrounding the professional, clinical, technological or human components of health organizations, and it appears that these are quite adequate in meeting society's current expectations (this is also reflected in opinion surveys of service users).[8] However, we also need to strive to meet our society's rising expectations, taking as our starting point an ethical commitment to quality, and an awareness of the limited budgets and resources available to each society.

Spanish society has seen radical changes to its core values in a very short time, and this requires health organizations to adapt rapidly. Organizations which are unable to respond positively to these changes will not survive.

Nursing organizations generally have bureaucratic structures which create an internal obstacle to a flexible response to demand. However, nursing care reflects the current values of society's members.

[8] *Barómetro Sanitario Diciembre 2002.* Centro de Investigaciones Sociológicas CIS.

5. Different models applied in care organizations. Different results?

The majority of postgraduate training programmes in nursing service management, such as the Master's Degree delivered by the University of Barcelona,[9] dedicate part of their programme to the study and analysis of models. This deals both with models as they derive from different theories of nursing (models of how the nursing discipline is shaped by different concepts of the profession and by individual realities), and also with how different models are applied to the organization, coordination and management of care units.

I will now focus exclusively on models for the organization of care units and, while I will identify some of the features of the most commonly used models in our health system, it is not my aim to assess which of these is better or worse as, in my opinion, the best model is that which is most appropriate to the social circumstances in which it is applied and to the values both of the manager and of the health professionals and service users.

In general, the models developed by care organizations in recent years are most widely disseminated in hospitals, although they have also been applied in other organizations such as primary care teams.

The explicit or implicit models used by care organizations, as for any business, can be analyzed using various criteria, such as the type of structure, how professional responsibilities are distributed, or the principal focus of management. Professors Duran and Mompart[10] identify the following structural models:

- **Bureaucratic:** organization in which authority is transmitted vertically, from top to bottom, and decisions are taken centrally. Very rigid.
- **Staff:** organization in which recognition is given on the basis of knowledge or specialization, and used to support the decisions taken by professionals, rather than to exercise direct authority over them. Flexible, depending on situation.

[9] Notes from Master in Nursing Service Management. University of Barcelona, 1995.

[10] Duran, M. and Mompart, M.P. *Administración y gestión. Enfermería* S21. Ed. DAE SL. Madrid, 2001.

- **Matrix:** organization which is the product of combining the two preceding models. It brings together vertical and horizontal structures in a mesh of lines of authority and experience which are partly rigid and partly flexible.
- **Flat or horizontal:** organization which seeks to keep the command chain as short as possible, and in which employees take decisions, have a high degree of autonomy and are directly responsible for their own actions. Very flexible.

Hermoso de Mendoza and Blasco at the 15th Working Sessions of the Spanish Nursing Association,[11] put forward an analysis of models based on the distribution of care responsibilities. They identified the following models:

- **Functional or task-based**
  Consists of allocating specific activities or tasks; these are distributed among the available professionals, with similar tasks being grouped together.
- **Patient/nurse based**
  Patients are allocated to nurses for each shift.
- **Patient/team-based**
  As above, but patients are assigned not just to nurses but to care teams, including nurses and nursing auxiliaries.
- **By reference nurse**
  Responsibility for caring for a patient is assigned to a single nurse, from admission to discharge. This nurse is then supported by other nurses, on different shifts, who assist with ensuring the continuity of each patient's care plan.
- **By programme**
  This consists of assigning responsibilities and organizing health professionals on the basis of care programmes or specific processes rather than on the basis of patients.
- **By clinical nurse**
  Consists of assigning work and responsibilities to specific individuals who are care experts, and giving them the job of proposing, promoting, implementing, evaluating and giving feedback on the specific care plans

[11] Hermoso de Mendoza, J. et al. Organización de los cuidados de Enfermería. *XV Sesiones de Trabajo de la Asociación Española de Enfermería Docente.* Barcelona, 1994.

of each unit. To some degree these individuals become the qualified, authorized reference points in the care units with regard to planning and evaluating care plans.

Finally, we can identify the following models on the basis of the principal management focus.

- **Material resources**
  This consists of coordinating and programming the organization of care units on the basis of material or technological resources, or of physical space.
- **Human resources (HR)**
  This consists of organizing the work on the basis of who is available and related employment considerations.
- **Knowledge**
  Consists of organizing units on the basis of the knowledge which professionals have (areas of expertise).
- **Competencies**
  Consists of expanding the knowledge or experience-based model to include the skills, abilities, qualities and preferences of the professionals who make up the care team, encouraging everyone to add value to their work.

Just as we have looked at some aspects of social change over the last 25 years, it is also true that there have been changes in the management models applied in nursing organizations.

Care organizations, through the different management models they have developed, reflect the changing values of the societies they serve.

Nursing organizations have arrived at the management of care after first focusing on the management of material resources and then of human resources.

Care organizations, in today's health and social context, must apply patient-centred management models which also promote the personal and professional development of nurses.

Daniel Goleman explains how, "the rules which govern the world of work are changing; what matters is not just intelligence, training or experience, but how we relate to ourselves and to each other."[12] If we accept this then the

[12] Goleman, D. *La práctica de la inteligencia emocional.* Ed. Kairós Barcelona 1999.

challenge for managers lies in their ability to deal with relationships, focusing on what is referred to as competency management: that is, striving to make best use of the skills, qualities, knowledge and abilities of our health professionals.

A competency-based management model requires that management of nursing professionals and of the organization in general is based on a whole-person approach which draws on people's knowledge, skills and abilities, and fully recognizes the added value which they contribute to the organization's final product.

It is my firm belief that there are clear qualitative and quantitative differences in the outcomes from different management models, something which is born out by Linda Aiken's research into the management model applied in what she calls 'magnetic hospitals'. According to Aiken, not only are these institutions successful at attracting professionals, but "it has been shown that hospitals which have magnetism have lower mortality rates than other comparable centres."[13]

6. Some thoughts about management and ethics. One commitment or two?

As a result of what we have already noted with regard to health organizations, anyone who takes on management responsibilities within them and is charged with adapting them to ensure that they meet rising expectations and respond to demand, is faced with the challenge of:

- giving clear expression to the values of each organization
- setting objectives and lines of development, and offering portfolios of specific services
- ensuring maximum quality of processes and results
- identifying the most efficient organizational models
- promoting scientific knowledge and praxis
- ensuring that staff have ownership of the organization's objectives

[13] Article by Linda H. Aiken and colleagues. Hospitales con magnetismo: un modelo de organización para mejorar los resultados de los pacientes. *Enfermería Clínica*, vol 5, no. 6, pp. 259-262.

- establishing ethical codes for behaviour, relationships and communication
- identifying stable financial formulae
- establishing a balanced relationship with the immediate and wider environment.

All of this is giving rise to major changes to the cultures and organizations within which professionals work, and is placing increased demands upon them, a factor which often explains the internal resistance to such change. And this, of course, makes the job of management particularly difficult.

Care and nursing organizations, like all modern health organizations, ask their directors, managers or leaders to take on the heavy responsibility of leading them into the future, ensuring their competency, quality, transparency, effectiveness and efficiency, and building relationships which are based on ethical principles. The reason why I have started by discussing the function and social value of the nursing professing, identifying some of the features of the health and social context within which nursing care is delivered, and summarizing some of the models used in today's care organizations, is to provide a framework for understanding the following basic belief:

The principle responsibility of nurse managers is to take decisions which direct the organization (people) along the paths chosen (strategies) in order to achieve their aims (objectives).

One of the main functions of those health professionals who wield management responsibilities is that of taking decisions. This is a far from straightforward process, and one which requires continuous commitment. At times, paradoxically, health professionals respond to this duty by avoiding taking decisions, by postponing them, or by delegating them inadequately. In short, they display an absolute fear of taking decisions even though, in dynamic situations such as those to be found in today's health sector, postponing or avoiding a decision really just means leaving it to chance, with the result that important managerial decisions in our organizations are taken randomly. It is worth remembering that, in the health sector, often the worst decision of all is to take no decision.

It is not possible to address, in a few words, the importance and significance of the many factors which influence the decision-making process, or the responsibility with which managers must utilize the resources available to them to ensure that their decision-making is of the highest possible quality.

As Pilar Antón of the University of Barcelona explains, "people's behaviour, whether following a routine or as the result of a specific decision, always involves choice, and reflects the values or principles of the person who has made it," and she argues that decision-making "should be based on giving the clearest possible explanation of the benefit to be gained and the various ways of doing so, identifying the values involved and prioritizing them for the given situation."[14]

We should be aware that everything related to the individual acquires, by its very nature, an ethical meaning or, to put it another way, that such decisions cannot be taken in isolation from human values. It has been stressed that nursing is also, as a result of its concern with caring for people's health, a discipline which cannot be exercised without an ethical commitment (whether explicit or implicit).

If the main management function is to take organizational decisions which guide the members of an organization to achieve its goals, does this mean that doubts exist with regard to the ethical content and commitment which form the basis of management? This question concerns the link between ethics and management in general, and specifically between ethics and the management of nursing care (which could also be described as the professional ethics of those whose responsibility it is to take decisions which affect people who care for other people's right to health).

At a practical level, the issue is often whether we can improve our ethical management. We can talk of individual ethics, involving the carer and the patient, and organizational ethics, linking the individuals who make up the organization, or perhaps it would be more logical to talk of ethics as a quality which is manifest in each and every human action, and which makes such actions good or fitting. In organizations, this ethical quality forms the basis for human acts and meanings and can endow them with extraordinary power.

It is also worth digressing a little in order to reflect upon another key management responsibility, that of maintaining the specific, and explicit ethical commitment of the organization, a commitment which must be expressed at every level and action of the organization's structure, in each of its policies, objectives, strategies, activities, communications, relationships and outcomes. This is an expression of the ethical values which bind the whole organization

[14] Antón, P. *Enfermería: ética y legislación.* Ed: Científicas y Técnicas Masson-Salvat enfermería, 1994.

together, and which cannot be found only in the actions of nursing professionals or managers, but which must be shared by the organization as a whole, in each and every one of its decisions, actions and outcomes.

As Agustín Domingo explains, "managing a health centre is not an ethically neutral enterprise." He stresses that, "we must offer ethical management models which, without neglecting individual ethical training, include the ethical dimension in health organizations too."[15]

Not being an expert in bioethics does not mean a lack of concern with or commitment to the ethical values and meanings of one's own decisions. Rather, concern with such ethical issues and their consequences for others should be a constant factor for all those who are responsible for taking decisions which affect others, whether they are nurse managers at the unit, service, area or team level. If bioethics helps nursing to take decisions about appropriate clinical practice, organizational ethics should also help nurses to take the right management decisions, and both types of ethics should converge and form the ethical basis for the organization as a whole. In the words of Pablo Simón, "private, microethical considerations, typical of clinical bioethics, increasingly need to be supplemented by ethical and organizational analysis on a larger scale."[16]

The managers of nursing organizations do not believe that we can comply with our management responsibilities simply by establishing a Bioethics Committee in the health centre, having recourse to professionals who have received training in bioethics, conducting training in ethical issues, or formalizing informed consent procedures. This is because ethics is not only an individual commitment between health professional and patient, it does not relate solely to the relationship between carer and patient, it is not a partial component. Rather, it is a global commitment which, taking respect for the dignity of the person as its starting point, affects every decision, action and relationship, and involves each and every member of the organization and everyone they relate to. Internal, external, individual, institutional and social relationships all occur within the context of what one might call the ethical environment or climate, and this should allow space for the plurality, diversity, differences, rights and obligations of all the people who relate to each other.

---

[15] José Ramón Amor y otros. *Ética y Gestión Sanitaria*. Documentos de trabajo 31. Ed. Sal Térrea. Madrid, 2000.

[16] Simón P. La ética de las organizaciones sanitarias: el segundo estadio de desarrollo de la bioética. *Revista Calidad Asistencial* 2002;17 (4):247-59.

This ethical climate is, to a large degree, the direct responsibility of management and requires the investment of a lot of energy and skill. Its importance means that nurturing it cannot be treated as just one more of management's responsibilities; rather, consideration of the impact on the ethical climate is something which should be incorporated into each and every one of management's functions and responsibilities, and in all the planning, organizational, strategy and assessment tasks within the organization.

Underlying the search for clear methodological reference points for quality principles and ethical principles is the question of the degree to which individuals working in today's complex, fast-changing and unpredictable professional environment need such points of stability to anchor our thoughts, decisions or actions.

To what degree do professionals need not just to do things well, but also to be able to demonstrate that they are doing them well, with reference to "social opinion"? To what extent is the search for the ethical principles of professional practice linked to quality principles? How far are these consolidated by individual responsibility or professional or social consensus? Is good practice guaranteed by individual opinions or by collective or social judgements?

Is individual legitimacy losing ground to collective legitimacy in today's society? Or does knowledge which is the product of experts working together and of agreed action strategies compensate for and strengthen areas which individual practice often neglects?

We have already seen how ethics and nursing share a commitment to people, and by the same token ethics is also inseparably linked to management and cannot be addressed in isolation or in a partial manner. This is why the four ethical principles also constitute the four ethical principles of management:

- Autonomy: decisions which promote an organization in which health professionals enjoy autonomy and are responsible for their actions.
- Beneficence: decisions which promote good.
- Nonmaleficence: decisions which avoid harm.
- Justice: Diego Gracia, Professor at the Complutense University, explains that, "justice is defined not by its consequences, but by its principles".[17]

[17] José Ramón Amor et al. *Ética y Gestión Sanitaria*. Documentos de trabajo 31. Ed. Sal Térrea. Madrid, 2000.

However, while we can identify a correspondence between the basic ethical principles and the ethical principles of management, there are also differences between how ethics is applied at the individual and collective level. One way of expressing this is to say that care professionals are generally concerned with individual well-being (that of the patient) while managers have to consider general well-being (that of the community).

In any case, my concern here is not to analyze different care management models with the aim of identifying which most thoroughly embodies the ethical dimension, because I believe that what is needed is not to identify different ethical management models but rather to analyze management models from an ethical perspective, as I do not see ethics as a complement to care management but rather as an integral part of it.

The ethical component of nursing management is inseparable from care management. The ethical meaning of human relationships and human interactions is felt by and is the responsibility of every single member of an organization.

The ethical commitment of nurses should be expressed in each of the planning, organization, management or evaluation activities in which they or their teams engage.

Ethics and management are united by their commitment to people, and for this reason every health professional in a nursing organization should be treated as an individual.

7. Ethical management models. To what extent are the concepts applied in practice?

Few would doubt that both care and clinical professionals are legally and ethically obliged to practise in a particular way, and that they should adhere to the ethical principles of autonomy, beneficence, nonmaleficence and justice, using evidence-based criteria for which professional consensus exists, backed up by adequate information, the confidentiality of which they are committed to protecting.

I have often asked myself why many managers appear to believe that these principles apply to professionals engaged in care or in research but do not seem to feel that they apply to the same degree to their own work as managers. If it is clear that health professionals participate in or take care decisions which affect other people, it is also clear that the work of managers is similarly based on taking decisions which directly or indirectly affect others (workers, patients, families, suppliers and so on). Why, then, should they not be bound by the same ethical commitments?

A more specific way of putting this is to ask:

- whether nurse managers consider it a duty and an obligation to ensure that decisions which affect others are based on ethical principles
- if they do this using decision-making tools which are backed by scientific evidence or professional consensus
- if they directly inform any third parties affected by the decisions, and actively evaluate all the opinions of other parties
- if they are committed to and respect the confidentiality of all the information to which they have access
- if they carefully record all their management decisions and activities, leaving written evidence of the basis for their decisions
- if they objectively evaluate the outcomes of these within the organization
- if they promote organizational approaches which facilitate the highest possible levels of autonomy for workers
- if, in their desire to improve things, they also give due weight to the welfare of professionals
- if they evaluate all the adverse effects of their decisions
- If they apply the principles of justice and fairness
- if they retain an open attitude which encourages a diverse and inclusive approach both when asking questions and when searching for the answers to them.

These considerations should not just typify the responsible conduct of nurse managers towards their organizations, but should also form the basis of how individual organizations, the health sector and civil society as a whole approach the rights and obligations of managers.

In an interview last March, Adela Cortina stated that, "the modern notion of the company necessarily includes ethical issues."[18] What logic is there in not requiring that professional managers provide the same guarantees, and use the same tools, evidence-based professional knowledge and clearly defined outcomes as we expect of care professionals? Why is it that we think it obvious that certain behaviours should be expected of care professionals but we do not have the same clarity when it comes to managers?

The real source of difficulties in the use of ethical management models is not in conceptualizing such models but rather in applying them to actual organizations. It is precisely in the implementation of management practice where inconsistencies arise.

Care managers, through discussion forums, with the participation of care professionals, can and must agree on the most important ethical issues to be reflected in the management of their units.

8. Proposals for management practice?

I would like to end on a more practical note, by putting forward some proposals to nurses who manage care units. It is my hope that these will help such nurse managers to address the ethical issues which arise in the course of their work, and will encourage them to think more deeply in this regard:

I. *Prior to taking on any management responsibility, it is worth ensuring that the individual ethical principles of the manager and the ethical values of the organization are consistent with each other.*
   For management to be consistent, there must be a broad set of values which are shared by the manager and the organization, even though these do not need to be absolutely identical. As this provides the basis of a consistent approach for every member of the organization, it is

[18] Interview in *Revista de Política Social*. March 2004

important that managers feel committed to the ethical values of the organization from the start, so that these values can then be embodied either explicitly or implicitly in all of their dealings with health professionals and patients. These ethical commitments should be expressed clearly and given priority in all important decisions and actions.

II. *We should always bear in mind, and keep a written reminder of, the reason for the care unit's existence, together with what ethical issues mean for the individuals who make up the organization (patients and nurses).*
Any nursing organization should express in clear and simple terms the qualities which constitute the reasons why it exists, because it is precisely by making such reasons explicit that we help to create a shared commitment among all members of the organization and to communicate this to patients and service users. The process of describing the organization's purpose should give a key role to employee participation and should address the following concepts:
   – MISSION. This sets out why the organization itself exists and the core values on which its service to society is based. Who and what we are.
   – VISION. This is a description of the purpose of our activity and what we want to achieve. What we want to be.
   – VALUES. These are the fundamental principles which refer to the moral or ethical significance of human behaviour and relationships. What value we give to people, and the significance we attach to some actions.
   – AIMS. These are the final objectives pursued by the organization. What we want to achieve.
   – ORGANIZATION. This is the structure and resources available to us. What we have and how we organize it to achieve our objectives.
   – OUTCOMES. These are the specific, quantitative or qualitative products or services. What we achieve.
   – ALLIANCES. The additional support that we have or which we can draw upon.

III. *With regard to the job of taking decisions – perhaps the key management activity – it is important to identify the specific steps which make up this process and ensure that the preparation stage has been completed adequately.*

Responsible decision-making should be the result of an analytical process (intellectual or material) which must include the following steps:

– INFORMATION. Sufficient knowledge of the situation to which the decision refers, identification of reliable information sources, and selection of important indicators or issues.
– OPINION. Study and choice of viable alternatives, evaluation of all options.
– DECISION. Selection of the preferred choice.
– COMMUNICATION. Everyone who is directly or indirectly affected by the decision should be informed of it and given a satisfactory explanation.
– ACTION. Implementation of the decision taken.
– EVALUATION of the outcomes achieved, and any corrective action to be taken.

IV. Managerial work, like any other professional activity in an organization, should be recorded in writing so that others are aware of what has been done, and so that its effectiveness can be evaluated.

The information record of the structure and organization of managerial work, and of all the management decisions affecting a care unit, should include the following daily working documents:

- RECORDS AND REPORTS OF MANAGEMENT ACTIVITIES
- "RECORD FOR EACH HEALTH PROFESSIONAL"
- "RECORD FOR EACH ORGANIZATIONAL UNIT"

I would like to end by thanking the Víctor Grífols i Lucas Foundation for having given me this exceptional opportunity to engage in the shared learning and reflection experience of this seminar on the management of nursing care.

Additional bibliography

Arroyo, M.P. and Serrano, A. *Ética y legislación en enfermería.* Ed. Interamericana McGraw-Hill. 1987

Joyce B. Thompson. *Ética en enfermería.* Ed. El manual moderno SA. Translated by Gloria Sierra, 1988

Lozano J.F and Siurana J.C. *Las Comisiones ética como mecanismo de integración de la ética en las organizaciones.* Papeles de Ética.Economía y Dirección no. 5. 2000

Medina C.D. *Ética y legislación.* Ed. Difusión Avances de Enfermería DAE SL 2000

Valls, R. Ética para la bioética y a ratos para la política. Ed. Gedisa, Barcelona, 2003 *Código Deontológico de la enfermería Española.* Madrid, 1989

SECOND PAPER

THE MANAGEMENT OF NURSING CARE

Núria Cuxart Ainaud

Explanation of the approach taken

I would like to start by thanking the Víctor Grífols i Lucas Foundation for inviting me to participate in this forum to consider the issues of ethics, nursing care and its management. I was too weak-willed to simply reject the invitation, and, despite a set of personal and professional circumstances which further complicated my task, I decided to accept this exciting but frankly rather daunting challenge because this is an area in which I am extremely interested.

I would also like to extend a special thank you to everyone here for participating in this event. Today I have been given the opportunity of expressing my ideas before an audience which contains individuals who have been and continue to be a major source of professional influence on me in the field of ethics, and others who, through their teaching, have helped me translate into professional practice what I consider to be the essence of the ethical dimension of care. I believe that exercises such as this should be more frequent among nurses and particularly among those of us who are involved with the management of nursing services.

Thirdly, I would like to give a little bit of background information about today's paper. As you may already be aware, the first step for me was to complete a reflective questionnaire which sought to explore the relationship between care management models and ethical care, and focused on the responsibility of managers for professional ethics. In other words, it invited me to consider ethical care as a question which concerns the management and organization of services and not just as an individual issue for each nurse. The aim was to:

- discuss the contribution of nursing care to health ethics
- draw links between different management models and ethical work by nurses.

In the light of these two aims, I was given a series of discussion questions which related to my professional experience in the areas of management, teaching and care.

- What ethical issues do nurses face in their daily work of caring for patients, service users and their families?
- What ethical problems are faced by nurse managers?
- How can we establish links between care and management so that ethical work is not just a personal issue for the individual professional?

- Can we include ethical criteria as measures of quality or high standards in the management of care units and health institutions?
- What are the ethical responsibilities of care nurses and nurse managers? Can we establish links between these sets of responsibilities?

The reason why I have referred back to this questionnaire is because, in order to answer the questions it contained and given the invitation to base my responses on my own experience as a manager, a teacher and a carer, I have decided to opt for a personal approach rather than a more formal one. I will now, therefore, explain a bit about my own background and about how my professional career has been based on three spheres of work: caring, management and teaching.

- My care experience (which at times I wish I could return to were it not for the fact that the intervening years might well expose my shortcomings!) has given me two things: a passion for nursing care, and an awareness of how the task of caring is a source of pride for those who perform it.
- My management experience, and in particular experience of providing leadership in nursing services which, as a result of the decision to adopt a conceptual model of nursing, are undergoing fundamental changes both to how their work is organized and to the notion of professional commitment.
- My teaching activities have helped me (and continue to help) to find new words and new approaches to encourage those who have decided to dedicate themselves to caring, and to convince all those involved in management that our job is to facilitate the activity of caring.

This perspective, based as it is on the three strands of my professional experience, has led me to the conclusion that the ethical problems which confront nurses in their daily work of caring for people are not so very different from the problems which confront nurse managers.

In order to explore this belief, I have structured this paper around the questionnaire, after first giving a personal overview of the environment within which "the act of caring" occurs and care professionals work, and concluding with some proposals as to how this can be managed. As part of this, I felt it was necessary to briefly summarize the general framework within which nurses and the nursing profession operate in order to identify the source of the majority of the conflicts we encounter.

General framework within which nurses and the nursing profession operate

There is a gap between, on the one hand, the concept of health and the model of healthcare embodied in the legal provisions ensuring Spanish citizens' constitutional right to the protection of their health and, on the other, the degree to which these ideas are reflected in day-to-day practice.

There is a range of European, national and regional regulations which govern and guide the organization, operation, objectives and activities of the health system. These are based on integrated, all-encompassing, dynamic notions of the individual, the environment and health which underpin a health care model which emphasizes health promotion, education, prevention and rehabilitation, rather than focusing exclusively on curing disease, as was the case in the past.

A similar process has happened with regard to the introduction of a user-oriented care model, in which quality of care should be the core around which a whole set of activities are organized. This approach requires careful analysis of the organizational framework in order to identify the basis for future growth and to ensure that such development focuses on the quality of care. This is no easy task, requiring as it does major modifications to the traditional organizational model which was based on medical specialisms.

What happens in the nursing profession?

Something similar occurs within the nursing profession. Very frequently one encounters working procedures in which the professional role of nurses is dictated by a biomedical model consisting of activities designed to support the diagnosis and treatment of disease, with rigorously standardized treatments for each illness. It goes without saying that this allows for very little individualization of care. Not only is this inconsistent both with the contents of nursing degrees and with modern concepts of the nursing profession; it is also at odds with the regulatory framework mentioned above.

There is general acceptance that the central concern of the nursing profession should be that of caring for individuals, families or communities for whom health experiences are part of their interaction with the world in which they live.

In 1995 an Expert Committee of the World Health Organization issued recommendations to member states urging them to formulate policies and action plans for the development of nursing as part of the reform of health systems, and encouraged them to include nurses in government bodies responsible for taking decisions on health issues.

The notion of nurses' leadership within the health services has been expressed many times and from a variety of viewpoints. In 1987 the then Director General of the World Health Organization, Dr. Maler, set out his belief that the quality of health care delivered was heavily influenced by whether nurses acquired new responsibilities and took on a leadership role. The title of his talk could hardly have been clearer: "Nurses lead the way". Exercising this collective leadership can only put nurses in a more positive position as a service profession, showing the way, guiding and accompanying service users, and using their position to raise awareness among the social groups that they care for and among those who have no decision-making powers, so that health is not just the concern of a few professionals but of society as a whole.

This leadership is probably the feature of today's nursing profession which is the most ill-defined and under-recognized. The influence and power of professionals depends on society's awareness of them, their image, and they ideas they transmit, and it is therefore no surprise that the traditional silence of nurses has meant that we have been under-acknowledged and undervalued.

Nursing care is the responsibility of nurses, and our professional actions must deliver results. It is this direct nursing care which creates the social image of our profession. The ordinary citizens who are the consumers of nursing and health services don't see either managers or the nursing profession as a whole. Instead, they experience a professional response which they themselves are able to evaluate directly and personally, recognizing its real importance at all times.

Just as in the case of the concept of health and the model of health care, there is a contradiction between the fact that, on the one hand, various international bodies have put forward this analysis and the nursing profession has continued to grow in importance (with all that this means for nurses as health promoters), while on the other hand we still have a disease-based health model which works within the biomedical paradigm and has little in common with a person-centred model of care provision. As a result, the role of the nurse is relegated to the performance of tasks in support of medical interventions,

and it is only with great difficulty that we are able to evaluate people's needs, their human responses, and the level of care they require, and to intervene in order to facilitate communication, education and so on.

Nurses and nursing care

Nurses talk about the need to reflect more on what it means "to be a nurse". Taking philosophy as our starting point, we arrive at a generic definition which fits with our theoretical positions, but in reality we are very far from achieving real consensus as to the significance and consequences of care and caring. It is as if the notion of care has been left at a purely conceptual level although, of course, we remain convinced that we have a unique, indispensable and irreplaceable contribution to make.

The difficulty that we sometimes encounter when trying to define the interventions that nurses make comes mainly from the fact that the value of caring is intangible and indeterminate, but also because nurses do not fully identify with their professional objectives. In the light of this, I think it is worth referring to the work of Rosamaría Alberdi on the elements which form the underpinnings of any profession, and which she uses as the basis for an examination of the nursing profession (Alberdi, 2003). She offers a general definition of these elements in the same terms as those used by the philosopher Adela Cortina (1997) who refers to them as an *intrinsic good*. This encompasses the profession's unique contribution to society, to whose maintenance it makes a vital contribution.

The *intrinsic good* of any profession remains unchanged, but it manifests itself in different ways, adapting to each age and set of circumstances. This concrete manifestation is what Alberdi calls the *professional discourse*. She understands by the term *professional discourse* the set of meanings which denote a profession's parcels of responsibility, identifying them and differentiating them from all the other responsibilities. This discourse consists of the following elements:

1. *The theoretical bases* which underpin the specific parcels of reality which the profession seeks to improve.
2. *The actual names,* that is, the professional language formed by the taxonomies which are used and the set of terms which are employed to identify behaviour and to communicate at a professional level.

However, although *professional discourse*, like the *intrinsic good* which gives rise to it, is a fundamental component of any profession, the element which really allows the profession to develop is the professionals themselves. These are the people who know how to convert the theoretical good into an actual service. As a result, the possibility of development comes from the third element: *excellence in professional performance*. "Excellent performance" refers to the fact that professional practice can only advance if it:

- solves the problems of service users
- makes clear the professional contribution to social well-being.

The fourth element described refers to *"market control"* and the fifth is *the capacity for association and representation.*

With this in mind, we can state that, if nurses are unable or unwilling to accept that "caring" is the fundamental objective of the nursing profession, then we place ourselves in a position which is full of contradictions, ethically questionable and, from a practical viewpoint, extremely uncomfortable. What is more, any nurse who has not adopted caring as her professional objective places herself in a quasi-fraudulent position with regard to those who receive her care, the students she trains, and the services she manages.

Adopting concepts of care

One of the major reasons for a failure to adopt and apply such concepts in professional nursing practice is the absence of a conceptual framework. To my mind, the risk of "walking without knowing where we are going" is that our journey will be fruitless or we will need to make a huge effort to travel only the shortest of distances. Worse still, we may lose sight of the reasons for being a nurse.

The other reason is the lack of methodological support based on instruments which have been specifically designed for our area of competence. I should stress here that I believe that, to understand the care process – whatever form this takes, however it is represented, and whether or not this is covered by another interdisciplinary instrument – is to understand and accept that caring is essential to the development of the nursing profession, but also that there is a final objective which not only transcends the activity of caring but which constitutes its raison d'etre. In other words, there is a very clear distinction between the instrument and what we seek to achieve with it. I therefore believe that there is a vital need for a theoretical construct which explains what we are trying to achieve: in other words, a conceptual model of nursing.

Despite the many criticisms which have been levelled at them, often because they were poorly explained, such models clarify the nature of nursing care by identifying the nurse's objectives, whether these are to promote the independence of the person being cared for, their capacity for self care, or their adaptation to healthcare processes, depending on the model adopted (Fernández Ferrín, 1997).

The evaluation and detection of problems, and the interventions and activities planned by the nurse, will be guided by the concepts of health, the person and the environment established in the model, and these can be used to define the service to be offered to the population. If we only take into account the biological dimension, we cannot offer care which addresses changes in people's mood, feelings of hopelessness, changes in people's ability to care for their own health, denial and so on, all features which in the biomedical model are "irrelevant" (Fernández Ferrín, 1997).

It is true that nursing services are complex, bringing together various activities performed by different nurses, carrying out a range of tasks in accordance with the objectives of the institution. It is equally true that the process of adopting a conceptual model within the care context is daunting, slow and complicated, even if one can count on the support, determination and perseverance of large numbers of nurses who have the commitment, motivation and training to implement it. Despite this, it is vital that we continue to move forward in creating a consensus about what we do, how we do it, what we use to achieve this, and what our aims are.

Even more important than this is the need to refocus the care model from a conceptual point of view so that it includes the individual as the main protagonist of health encounters, something which involves moving away from the traditional paradigm towards other, more integrated paradigms which give equal importance to every aspect of the individual. Nurses have come a long way towards acquiring the new forms of knowledge which match the demands citizens now make of health services, and health organizations should be aware of this. The challenge for nurses is to make this progress visible.

This concludes my personal reflection on the environment in which nurses and the nursing profession operate, an environment which is, in my opinion, the source of many of the problems identified in care, teaching, management and research practice. I will now directly address the questions put to me by the Foundation, although in so doing I will continue to base my responses upon my own professional experience.

Discussion questions

What ethical issues do nurses face in their daily work of caring for patients, service users and their families?

Pilar Antón and Montserrat Busquets, in their book *Ética y Legislación en Enfermería* (Antón, 1994) [Ethics and Legislation in Nursing] set out the ethical principles defined by Tiroux (1980) which should not only govern professional nursing performance but should also help the nurse in the rest of her life, and these provide an outstanding basis for excellent performance. The ethical principles which they propose to help us identify what course to follow are: the value of life, what is good and right, justice and impartiality, truth and honesty, and individual freedom.

As was the case of the conceptual model of nursing discussed above, these principles should be understood as a guide which allows us to act in the interests of the person being cared for.

By the same token, the bioethical framework, as the first point of reference for health professionals, has been adopted by a nursing profession which is dedicated to caring for and promoting life and which understands health as the potential to develop the capacities of every human being and to progress in their life project (Alberdi, 2004). The principles which make up this framework (Nonmaleficence, Beneficence, Autonomy and Justice) are not always accorded the same degree of importance in health care. *If we adapt the medical language used by Gracia (1997) to the nursing profession, we can say that the moral justification of an act of care is based not only on nursing criteria (the principles of nonmaleficence and beneficence) but also on the choices of the person being cared for (the principle of autonomy) and on socioeconomic considerations (the principle of justice).*

The health system is currently progressing from the ethics of beneficence to the ethics of justice, by way of the ethics of autonomy, and ensuring that it achieves the initial goal of embodying these four principles is clearly one of the key tasks which nurses must perform. Indeed, it is nurses, acting in their role as moral innovators, who must convert the principles of autonomy and justice into specific acts and ways of behaving towards service users.

Failure to adopt an ethical framework, like failure to adopt a conceptual model of nursing, greatly complicates decision-making for nurses, something

which is clear from my own professional experience (the basis on which I was invited to give this paper).

While I accept that all classifications are imprecise and open to debate, I have taken the liberty of identifying four types of ethical problem:

- Those arising from the orientation of health institutions, from traditional dynamics within the health system such as selling to people who access the health system the idea that the best care to be obtained from the system is that which is administered using medical equipment; when the nurse cannot attend to all the patients at once and has to prioritize while striving to ensure that this decision does not harm those who have to wait; when an inexperienced nurse is assigned to a position for which she is not yet prepared, and her colleague is unable to help her, when the working conditions are far from ideal and restrict the quality of the care delivered, or when some types of care are very expensive and this causes problems.
- Those arising from the work of other professionals, when informed consent is not part of the information process, or when only those patients who are responsive to treatment receive the best care, with the result that the chronically ill, the aged or those with terminal illnesses at times do not get the care they are entitled to.
- Those arising from direct care being administered in a way which clashes with the person's cultural practices and religious beliefs, or those concerning issues such as how far one should go in mitigating suffering, or how to prevent contagion while also respecting confidentiality. And issues of life and death.
- Those arising from failure to embody the intrinsic good of the profession, giving support to the values and decisions of the individual as someone who is responsible for taking independent decisions and who is in control of their own destiny. When the nurse is unable to decide when and to whom to delegate a task or, on the contrary, when somebody tries to delegate a task to the nurse which falls outside of her competencies. Or when the nurse has the opportunity of sharing valuable information and helping to take decisions which are consistent with her values. Or when she has to report a colleague's misconduct, or when service users' needs are not met.

What ethical problems are faced by nurse managers?

I already commented at the start of this paper that I suspect that the ethical problems faced by nurses in their daily work of caring for people do not differ greatly from those faced by nurse managers.

At the same time, it is also worth recalling that the role of the nurse manager has traditionally consisted of planning, organizing, directing and monitoring financial, human and material resources with the aim of achieving the objectives of the organization as effectively as possible. For this purpose, the manager draws on knowledge from disciplines including management science, economics and psychology, all of which clearly have a vital contribution to make to management practice in nursing care. However, Meleis and Jennings (1989) in Kérouac (1996) argue that the management of care should not be based solely on administrative theories or theories borrowed from other disciplines, but should also be based on theories which come from within the discipline of nursing. They argue that the health and well-being of an individual, whether this is somebody who is ill, a family member, an employee, or a carer, should be at the very centre of the activity of managing nursing care. The role of the nurse manager, then, consists of supporting care staff. That is, nurse managers should seek to ensure that the aims of nursing practice can be met through the action of care staff. Such management requires thorough knowledge of the concepts created within the discipline, together with creativity, a desire to change, and an acceptance of risk. To this I would add credibility.

It is true, citing Kérouac once again, that the environment in which nurse managers operate presents many situations where there appear to be conflicting priorities, including: the financial survival of the centre versus the human values of nursing care, the continuity of care versus the instability of work teams, hierarchical authority versus the autonomy of the care staff, power struggles versus intra- and interprofessional cooperation, standardization versus respect for diversity and individuality, bureaucracy versus participation, the impersonality of structures versus commitment to individuals, and the use of technology versus human values, to name but a few.

However, the management of care does not consist solely of resolving such conflicts, and in any case, the position of those in care management and leadership positions is clear, because it is these nurses who have the job of

ensuring that resources are available, maintaining the organization, developing procedures to guarantee the quality of care, and promoting the continuous development of the staff for whom they are responsible. They are not direct carers, but their role in caring, by contributing to nursing activity which directly affects service users, is fundamental. Similarly, their ultimate objective is a nursing goal: that of caring for and improving the health of service users, even if they will probably never have direct contact with these people. Managers therefore exercise a kind of shadow leadership which should always accompany the direct carer.

I don't like to generalize, because I know many excellent care managers, particularly at the middle levels but, in many cases nurse managers have fallen into the common administrative error of acting as if the management activities they perform are an end in themselves, forgetting that these activities are meaningless without an end goal which, in the context of nursing services, can only be the activity which defines the nursing profession as a whole and underpins its maintenance and development: the delivery of nursing care.

Traditional models of nursing management should draw on recent, person-oriented ideas. These ideas relate to leadership, motivation, cooperation and participation and, precisely by improving our knowledge of people, provide a better basis for management processes aimed at utilizing the full potential of the staff for whom managers are responsible and of the resources available. This is why nurses make excellent managers.

Innovative nursing management, then, is strongly influenced by an explicit conception of nursing care which helps it in two fundamental ways: to implement administrative practice which is based on knowledge of the individual and, if the manager's main concern is the health of individuals and of the environment, to promote contexts which are more favourable to the care of individuals. Just as if the manager were a care nurse.

How can we establish links between care and management so that ethical work is not just a personal issue for the individual professional?

This, to my mind, is strongly linked to the final question:

What are the ethical responsibilities of care nurses and nurse managers? Can we establish links between these sets of responsibilities?

I will now seek to answer these. In so doing, we must consider two fundamental issues: the relationship between the professional project and the institutional project, and the relationship between individual and collective professional commitment.

Nobody any longer disputes that innovations in service organizations are not viable if professionals are not committed to the organization's objectives. I referred above to how difficult it is to identify innovative elements (which are far from common in health organizations) to ensure that development corresponds to a care model which is oriented towards the user of the health service. This requires a completely new notion of management, based on a participatory culture and led by a facilitative manager. The reality is that it is health professionals who best know the most effective ways to organize specific activities. What they need is the confidence to implement these, and it is the job of managers to build this confidence.

Indeed, this commitment is something that must come from both sides. A culture of responsibility requires that each of the different components of an organization fully accepts its responsibilities instead of seeking to transfer them on to others. It therefore requires that conscientious professionals work both independently and in collaboration with others, and that they believe in the possibility of sharing the interests of groups which may appear to be contradictory, such as institutions and professionals.

The will to deliver excellent nursing management must be based on a professional project which is at the service of an institutional project. In other words, a project which embodies the values of the organization and those of the profession itself so that there is what Montserrat Teixidor (1995) defines so appositely as an "agreement between projects". If this situation does not exist, then the actual circumstances must be identified and recognized, and the need for such agreement emphasized within the institution so that the proposed professional project is gradually translated into an institutional project.

This must:

- include a clear conception of the nursing care which guides nurses in their practice, defines their role, identifies their values and formulates the proposed objective
- include the values of the organization and of the profession itself
- determine the policies of the nursing services, and have a universal character: that is, to paraphrase Alberdi once again,

– to promote the commitment of professionals, and
– to make it possible to assess the coherence of specific actions on the basis of the professional development aims.

It is important not to forget that nurses work in health or social-health institutions and that it is only through these that we reach the service users. The provision of care is why these organizations have been established, and what justifies their existence and gives them meaning is their ability to meet the care requirements of the individuals who access them. Our aim is not to be experts in nursing concepts, but rather to provide excellent care.

What I have said so far relates to the first question: that regarding the relationship between the professional project and the institutional project. I will now turn to the issue of the relationship between individual and collective professional commitment.

To answer this second question I shall once again quote Rosamaría Alberdi, who, in discussing the commitment of nurses to ensuring a caring future, focuses on an analysis of the values which need to have been adopted if nurses are to be committed to providing excellent care (Alberdi, 2004).

She starts from the notion that *"to be committed" is to voluntarily take on a responsibility as the product of a deeply-felt belief that this is the way to achieve one's professional aims. Or, to put it more precisely, nurses' commitment is the set of responsibilities which they take on – at all times – as a result of adopting the intrinsic good of the profession, which is that of caring.*

Having formulated some specific proposals regarding the circumstances which help to develop nurses' commitment to the society for which they care, I will end this section by referring to the issue of meeting one's commitments to oneself. In this regard it is worth recalling Watson's observation (1988) that *caring for and loving oneself precede caring for and loving others.* Having adopted caring as the end goal of the profession, the key to this commitment is to find a harmonious way of combining individual and professional values to achieve a level of "moral comfort" which results in satisfaction and pride in one's achievements.

Can we include ethical criteria as measures of quality or high standards in the management of care units and health institutions?

I do indeed believe that it is possible to include ethical criteria when measuring quality or service standards in the management of care units and health institutions.

I recently contributed to a study which sought to identify attitudes and skills in the nursing profession with the general aim of helping nurses to develop processes whereby they can acquire concepts of caring.

As I have already said, this process can only be implemented of it meets the following criteria:

- the adoption of the provision of care as an intrinsic good* of the profession
- valuing the need to perform one's day-to-day work in a professional manner.

Taking these two notions as a starting point, we proposed a series of indicators, in two stages. The first stage involves analysis of the existing nursing service with relation to:

- The nursing service: does the service offered embody the intrinsic good of the profession and promote excellent professional performance?
- The users of the nursing service: do service users identify the nursing contribution as a specific, distinct service which is necessary in order to solve problems relating to the satisfaction of their basic needs?
- Interdisciplinary working: what specific contribution do nurses make to interdisciplinary working and to the provision of global care for service users?
- The organization of the centre: does the organizational system of the centre make it possible to provide the nursing service we desire?

The second stage involves identifying care areas in order to find out what are the most frequent nursing problems among the population of service users.

I will conclude this paper by giving a summary of what I believe to be the typical characteristics of a nurse who works from a caring perspective.

---

*By the term "intrinsic good" I mean that which constitutes the profession's unique offering to society and which is vital for the maintenance and development thereof.

- She is instinctively drawn towards intimate relationships and to the task of caring, she recognizes herself in the performance of such tasks, and she feels that her contribution is recognized by others.
- She is prepared to take on the work of others when necessary, but without supplanting them, and she is always aware that in the end it is the patient who achieves results.
- Her aim is to ensure that she becomes redundant as quickly as possible in her work: in other words, she is able to promote self-care.
- She does not believe that her contribution is limited by what qualifications she has, and she is aware that the nursing perspective has a vital and unique contribution to make to every area of health development.
- She knows how to appreciate the recognition she receives for work which is performed in the "dark zone"* where there is no such thing as a monopoly of knowledge.
- She is proud of providing professional care and demands that due recognition be given to the caring orientation.

Thank you very much for your patience, for your attention and, above all, for giving me the opportunity of trying to share with you the image of the nurse we want to communicate, the professional contribution we want to make, the actions we want to perform, and the nursing care we aim to offer.

* This term refers to the private space in which the nurse-patient relationship occurs, a relationship which is characterised, among other things, by a difficulty in crossing over into the social sphere. For a more in-depth discussion of this idea, see Rosamaría Alberdi Castell Las enfermeras del tercer milenio. *ROL de Enfermería.* 178 [43-50].

Bibliography

Alberdi Castell, Rosamaría. Las enfermeras del tercer milenio. *ROL de Enfermería*, no. 178. Barcelona, 1993.

Alberdi Castell, Rosamaría. Género, Enfermería y desarrollo profesional. *XVI Sesiones de Trabajo de la Asociación Española de Enfermería Docente*. Palma de Mallorca, 1995.

Alberdi Castell, Rosamaría. Un futuro de cuidados. *XXI Congreso Nacional de Enfermería en Salud Mental*. Bilbao, 2004 (Unpublished).

Alberdi Rosamaría, Artigas Berta, Cuxart Núria, Agüera Ana. Guías para implantar la metodología enfermera. *ROL de Enfermería*, vol. 26, no. 3. Barcelona, 2003.

Collière, Marie Françoise. *Promover la vida*. McGraw-Hill/Interamericana de España, S.A.U. Madrid, 1997.

Fernández Ferrín, Carmen. La investigación en cuidados y el desarrollo disciplinar. Libro de las *XVIII Sesiones de Trabajo de la Asociación Española de Enfermería Docente*. Cadiz, 1997.

Gracia Diego. Ética, salud y servicios sanitarios. In García MM, editora. *Ética y salud*. Escuela Andaluza de Salud Pública. Serie monografías number 22. Granada, 1997.

Kerouac, Suzanne et al. *El pensamiento enfermero*. Masson. Barcelona, 1996.

Mompart Garcia, M. Paz y Duran Escribano, Marta. *Administración y Gestión*. Difusión Avances de Enfermería (DAE). Madrid, 2001.

Teixidor Freixa, Montserrat. Los espacios de profesionalización de la Enfermería. *Revista Enfermería Clínica*, vol. 7, no. 3. Barcelona, 1995.

DISCUSSION QUESTIONS

Please discuss the following questions on the basis of your professional experience in the management, teaching and/or care context:

1. What ethical issues do nurses face in their daily work of caring for patients, service users and their families?
2. What ethical problems are faced by nurse managers?
3. How can we establish links between care and management so that ethical work is not just a personal issue for the individual professional?
4. Can we include ethical criteria as measures of quality or high standards in the management of care units and health institutions?
5. What are the ethical responsibilities of care nurses and nurse managers? Can we establish links between these sets of responsibilities?

CONTRIBUTIONS OF THE SEMINAR PARTICIPANTS

We have organized the contributions of participants starting with those which directly addressed the discussion questions and following with the other contributions, in alphabetical order.

1. Pilar Antón, Lecturer at the School of Nursing at the University of Barcelona

"I believe that the ethical responsibility of care nurses is something which comes from their own conduct – providing excellent care – while the ethical responsibility of nurse managers is to ensure the conditions for providing this care, establishing corrective mechanisms where there are deficiencies, and taking steps to guarantee the quality of care."

First of all, I would like to express my gratitude to the organizers of this initiative which has brought together nurses working in the management, care and teaching settings so that we can share our experiences both with other members of our profession and also with professionals working in other disciplines. This can only help to enrich our dialogue and ensure that our debate is open to a wide range of influences.

It is difficult for me to respond to everything which has been said by the two speakers and by those participants who have already spoken. The organization of the seminar, which for good reasons means that it has not been possible to make "on the spot" contributions, means that my intervention may seem a little disjointed. Despite this, I shall follow the structure suggested by the organizers and will try to respond to the initial discussion questions.

What ethical issues do nurses face in their daily work of caring for patients, service users and their families?

Núria Cuxart has divided these into four categories:

- the orientation of health institutions
- the work of other professionals
- caring for people
- embodying the intrinsic good of the profession.

I fully agree with this analysis. The ethical problems faced by nurses while they care for people arise either from conflicts of values or as a result of not knowing what the appropriate behaviour or approach is. Such conflicts or

doubts may arise in the context of the nurse's relationship with her patient and with the patient's friends and family, in her relationships with other professionals participating in the care process, and in her relationship with the institution where she works.

Within the context of the nurse's relationship with her patient and with the patient's friends and family, questions which may arise include the following. Who should inform the patient? Does a lack of information on the part of the patient with regard to the care process make it more difficult for the nurse to perform her work well? Who should receive the information? When should we question the capacity of the patient to actively participate in the care process? Which opinion should prevail when the family disagrees with the professional advice? Who ensures that the patient's wishes are respected? Which team members should have access to the patient's data? What does the right to confidentiality imply?

In relationships with other professionals, the key questions relate to team working and the sharing of ethical responsibility for results. The concept of interdiscipliniarity should influence the way relationships between team members are viewed, and all the participants in the situation should be treated as equals. Ethical questions include the following. How is the relationship between professionals participating in the care process defined and implemented? What happens when there are different professional opinions regarding the maintenance of given treatments or the request for certain diagnostic tests?

The relationship with the institution is another area where nurses can encounter problems. Mercedes Ferro has already highlighted some of these, such as lack of recognition of nurses within the organization, limited professional autonomy, limited or inadequate staff resources: the nurse–patient ratio is clearly insufficient in most services, and this is often compounded by a lack of material resources. At times, these factors are given as a justification of inappropriate or even unethical care. In my opinion, ethical care is closely linked to the nurse's professional and personal attitudes, and while these can of course be influenced by adverse working conditions, attitudes in themselves are not dependent on resources or recognition. Even within such contexts, it is possible to provide ethical care. At times the failure to work from an ethical perspective is the result of not having thought sufficiently about the respect we should show towards the person we are caring for.

What ethical problems are faced by nurse managers?

The principal problem, highlighted by nurse managers present here, is that of combining the institutional project with the professional project. For this to happen, both projects must be explicit, clearly defined and known to all the members of the organization. The institutional project must recognize nurses as professionals, and ensure that they feel that they belong to the organization, but it is clearly difficult to achieve this so long as nurses do not feel that they are valued and when their relationship with managers is unequal.

The professional project, in the words of Núria Cuxart, should incorporate or define clear conceptions of the care, the values of the organization, and the values of the profession, and should provide a set of general policies which make it possible to promote the support of professionals and which advance professional development. While it is true that there is a wide range of management models in use among nurse managers, I believe that in order to take the initial step of bringing together the institutional and professional projects it is essential that nurse managers manage care rather than staff and resources, and that they keep sight of the fact that their job is to make it possible to provide excellent care.

How can we establish links between care and management so that ethical work is not just a personal issue for the individual professional?

To some degree I have already answered this question: by clearly defining the two projects – institutional and professional – and ensuring that both nurses and managers are committed to them. We can also establish links by focusing management on professional competencies and values.

Fortunately, a lot of progress has been made both in the provision of care and in our concept of the nursing profession, but there is still further progress to be made along these lines with regard to the issues addressed in this seminar. Among these, I would like to stress the need to have a policy to deal with the pressures of the demand for care, which seeks to improve the health care received by users of health centres. This means not just guaranteeing professional competency but also establishing a staff ratio which gives nurses space to reflect upon and organize care as competently as possible, which ensures that nurses have the time and knowledge necessary so that they can establish a relationship with the patient which allows them to help patients clarify their personal values with regard to their health problems, helping

patients to take health decisions, to learn new ways of living and new habits, to ensure their safety, and so on. In order to do this we must stop employing and allocating nurses to do jobs for which they do not have the necessary skills and competencies, and we should make sure that professionals are not asked to carry out work without having received the appropriate training.

Can we include ethical criteria as measures of quality or high standards in the management of care units and health institutions?

Of course we can. In fact, quality is already measured in health organizations even if, in my opinion, such measurement tends to be patchy. We already have quality standards, and there are questionnaires which can be used to measure whether the various elements of these standards are being achieved or not. Patients and service users are also asked about their levels of satisfaction. However, these measurements are not integrated with the implementation of care activities and are therefore insufficient from an ethical point of view. Examples of ethical criteria include: the identification of evaluation criteria regarding respect for human rights in each of the activities or care duties performed; how information is provided to patients and whether they understand this information; the quality of answers to doubts or questions; respect for the confidentiality of all information; and the inclusion of criteria governing respect for privacy in all procedures and techniques.

At the same time, it is important that we measure not only the quality as perceived by the patient or service user but also by the organization's employees. Health organizations, like any organization, consist of service providers and service users, and for this reason the opinions of both parties must be gathered using quality criteria which will inevitably include indicators of ethical criteria. There is an ethical component of every clinical activity, and it is impossible to separate this component from the activity of which it forms an essential part.

What are the ethical responsibilities of care nurses and nurse managers? Can we establish links between these sets of responsibilities?

I believe that the ethical responsibility of care nurses is something which comes from their own conduct – providing excellent care – while the ethical responsibility of nurse managers is to ensure the conditions for providing this

care, establishing corrective mechanisms where there are deficiencies, and taking steps to guarantee the quality of care.

Care nurses contribute their skills and knowledge, and they have an ethical and moral duty to keep these up to date in order to ensure the excellence of the care they provide. The job of nurse managers is to ensure that this care is provided in the best possible setting, and to provide the resources needed so that the nurse can make an effective contribution within the organization and meet her commitment to the organization's objectives. This cannot be achieved unless the nurse managers look after the care nurses, and this requires the establishment of a professional relationship based on equality, the promotion of time for reflection, establishing fair criteria when assessing nurses' performance, rejecting unfair treatment, encouraging the development of spaces and time for discussion and the emergence of consensus, and many other things which I am sure other participants will go on to mention.

2. Ester Busquets i Alibés, Nurse, Borja Institute of Bioethics

"Ethics is not just an individual issue for every professional, but is also an institutional issue."

It seems that in recent years we have established a false dichotomy between nursing management and nursing care, a process which parallels the situation in other health professions. Debating this issue with the aim of breaking down this division therefore strikes me as an important and indeed necessary task. A wide-ranging and respectful dialogue between care nurses, nurse managers and teachers will help us to realize that, as Núria Cuxart reminded us in her paper, the jobs of managing and caring are complementary rather than conflicting: "The role of the nurse manager is to support care professionals." Establishing pathways of communication and cooperation between these two roles can make a significant contribution to the promotion and development of our profession. Ethics is not just a personal but also an institutional issue.

Ethical problems faced by care nurses and nurse managers

Identifying the ethical problems faced by nurses, whether in care or in management, is the vital first step in analyzing them and looking for the best way of solving them. The following list (which is by no means exhaustive) identifies some of the situations which may give rise to ethical problems for care nurses and nurse managers.

Following King, who says that care nurses, "teach, guide and orient individuals and groups to keep themselves healthy, and care for them when they are sick," we can group the situations where there is a risk of ethical conflict into the following types:

a) Those deriving from the institution. Here we can identify excessive workloads as a result of the high number of patients under the care of each nurse and the complexity of their health problems, the need to keep abreast of professional knowledge, the significant role of technology in care which often means that care focuses on biological or technological issues rather than on people and experiences, and the difficulty of combining care with research, among others.
b) Those deriving from patient care. Among these we can identify demands for help from the patient or his family which go beyond the competence of the nurse and which belong to the personal rather than to the professional realm, the low recognition which is sometimes

accorded to care and the fact that it is often not viewed as a professional activity, the cultural, ideological and or religious diversity which the nurse is meant to respect and which may form the basis of visions of health and human needs which are very different from the nurse's own vision of these.

c) Those deriving from working in multidisciplinary teams. A possible source of ethical problems here is the existence of authoritarian hierarchies which prevent or obstruct working on the basis of shared values in care teams, causing a lack of cooperation between team members and a whole series of potential ethical problems such as, for example, lack of coordination in providing information to patients.

With regard to nurse managers, and in the light of their objectives of planning, organizing, managing and monitoring financial and material resources and staff in order to effectively deliver the organization's objectives, the situations which can generate ethical conflict include the following:

a) Those deriving from the institution. Lack of financial and material resources and staff is one of the main causes. However, while resources are vital, they do not on their own guarantee ethical care. We should recognize that at times organizational decision-making does not take sufficient account of ethical criteria. Nurse managers also have to face up to their responsibility to manage on the basis of the values of the institution and the humanistic values of nursing care; indeed, it is the job of managers to integrate these two sets of values and ensure they are compatible.

b) Those deriving from the patient. The main situation which gives rise to conflict derives from the difficulty of distributing resources fairly on the basis of the care needs of patients and their families. At the same time, managers must plan services so that high-quality care can be provided at the lowest possible cost to the institution.

c) Those deriving from the health professionals and staff for whom nurse managers are responsible. In institutions with a large number of staff, an added complication is lack of awareness of the skills of the care staff and the challenge of finding effective ways of ensuring continuous professional development among employees.

Another key issue is the lack of spaces for communication between care nurses and nurse managers where they can share values and find better ways of providing care in each institution or service, respecting ethical criteria and resolving conflict situations in the best way possible.

From professional ethics to institutional ethics

It could be argued that the professional ethics of nursing are almost as old as the profession itself, and this is demonstrated by the history of the profession and is evidenced in the many statements nurses have made with regard to nursing ethics. By contrast, in the institutional context ethical considerations are a more recent phenomenon. It was not until the 1970s that it became fashionable, first in the United States and then in Europe, to talk of "business ethics", "company ethics", "organizational ethics" and "management ethics". At this point people became aware – better late than never, we might add – that ethics was not just an individual issue for each professional but also an institutional issue. This means that both hospitals and primary care centres and the nurses who work in them must follow moral guidelines (ethical criteria) in accordance with the aims of the institution and of the profession, and it is these aims which give meaning and social legitimacy to institutions and the nursing profession. If we argue that both professionals and institutions must behave in a way which is consistent with certain standards of morality, then we must ask what moral standards are or could be associated with care nurses and nurse managers.

Ethical responsibilities of care nurses

The ethical responsibilities of care nurses are set out in the ethical codes of the profession. The aim of these responsibilities is: 1) to always promote the patient's well-being, to inform him, respect his privacy, help him in the process of dying, and so on; 2) to work for the development and promotion of the profession; 3) to play a full part in multidisciplinary teams, to contribute to taking care decisions and assessing their outcomes; 4) to work to further the aims of the institution.

Ethical responsibilities of nurse managers

Unlike care nurses, the ethical criteria which should guide the behaviour of nurse managers have not yet been subjected to careful consideration. We know what the technical task of these nurses is, but we are not yet very clear what it takes to ensure that their work constitutes "ethical management".

Before looking at some of the characteristics of "ethical management" we should recall that every institution has a purpose which gives it meaning and provides it with social legitimacy. In the case of a hospital or health centre, this purpose is to provide a health service to citizens who need it and to educate people in order to promote health, and prevent disease and the risks which

may result from these diseases. It is essential for the survival of the institution to be as clear as possible about what the criteria of good service are. If one argues, rightly, that "without ethics there can be no profession", it is also true that "without ethics there can be no institution". We should remember that the objectives of health structures are achieved by the people who work in the institution. For this reason, nurse managers bear the following ethical responsibilities towards care nurses:

- to promote knowledge and support of the ideals or values of the organization
- to encourage responsibility for and participation in the institutional project
- to make it possible for every nurse to perform her duties effectively, in accordance with her skills
- to promote initiative and creativity among nurses
- to facilitate communication between nurses and the multidisciplinary team
- to introduce spaces for communication between care nurses and the nursing management
- to encourage the continuous professional development of nurses (both scientific-technical and human)
- to review the work of nurses in order to assess their levels of self-esteem and sense personal achievement
- to promote quality of life in the workplace.

Starting with these elements, it is possible to configure a new management model in which nurse managers will work more closely with care nurses, helping them to achieve excellence in nursing practice, one of the most important ethical objectives of all.

In conclusion, we should reject approaches which treat the care and management functions as incompatible rivals. The two jobs are part of a single human and social project, and we should therefore share ethical values and ideals, looking for ways to give them expression in each and every one of our professional actions.

3. Rosa María Blasco, Lecturer at the School of Nursing at the University of Barcelona

"The challenge facing the nursing profession is how to continue to provide ethical, person-centred care which recognizes the true significance of life, health and death within organizations which are striving to achieve efficiency and cost-effectiveness."

1. What ethical issues do nurses face in their daily work of caring for patients, service users and their families?

Our health systems have been in a state of permanent change for a number of years and the majority of the reforms being proposed recognize equity and efficiency as fundamental and important principles. For nurses to understand and participate in these changes they need to set their professional values in the context of the new cultural, socioeconomic and political environments in which they carry out their professional activity, reaffirming the philosophy of nursing while adapting it to new healthcare contexts. In this way the ethical criteria of the profession can be restated without losing sight of the main focus of nursing: the person who needs professional care to maintain or improve their health or to die with dignity.

Responding to the health needs of today's patients and service users represents a major challenge for nurses. Caring is becoming increasingly complex, and nurses have to continuously update their knowledge. At the same time, we need space to reflect upon the human dimensions of care and how it affects people's dignity, and nurses must feel that they are supported when taking decisions. This combination of knowledge, reflection and support allows care nurses to incorporate ethical criteria into their care and to develop ways of acting which reflect these.

While it is true that ethical caring is largely a question of the nurse's attitude – an attitude which is reflected in a particular way of conducting interpersonal relationships with patients and with other members of the care team – it is also true that the care context often does not foster such attitudes. For example, nurses may need to inform, advise or teach patients but find that there is no space in which to establish a therapeutic relationship where the patient's privacy is protected, or that there is simply not enough time for such relationships as a result of understaffing.

In summary, care nurses must deal with a series of ethical problems relating to the care they provide for their patients, and these problems involve material

and human resources and may be complicated by lack of training in ethical issues or the absence of support structures should disputes arise. Resources, training and support from the organization are perhaps the three key elements which contribute to the detection and resolution of ethical problems in daily care duties.

2. What ethical problems are faced by nurse managers?

Nurse managers face two fundamental problems: the first of these comes from managing staff instead of managing care, and the second comes from losing touch with nursing knowledge and placing more emphasis on receiving management training than nursing training. This, together with the pressures on care services, means that one of the problems facing managers is how to match nursing staff with the care needs of patients and their families. In many health centres, the fact that there are not enough nursing staff to cope with existing workloads means that nurse managers have to deal with situations where not enough nurses are available or where those nurses who are available lack the necessary skills, and sometimes this even means that managers have to decide to reduce the quality of care.

In 1992 the International Council of Nurses brought together a group of experts and asked them to draw up a document on "The cost of nursing services", considering some of the issues faced by nurses trying to deliver social and health care. The document argues, among other things, that, "almost everywhere nurses are paid for the activities they perform, not for the responsibilities they hold; for tasks rather than for expert knowledge. Over half of what nurses do for patients cannot be explained with reference to medical diagnosis or length of stay, the criteria on which payment is made and which clearly prejudices centres which provide more care, such as medium- and long-stay centres." It goes on to state that nurses work "with their heads" and not just "with their hands", but have traditionally been reluctant to discuss financial issues. This is why nurses should take the lead in studying and assessing the health impact of the services they provide and the costs associated with these. It is vital to understand the professional importance of linking nurses' responsibilities with the quality of care and the cost-effectiveness of their services.

This implies shifting from a biomedical model to a financial model which places greater emphasis on effectiveness and efficiency than on a set of professional values concerned with providing a high quality of care in line with

a humanistic model in which managers provide the conditions which allow this to happen. In other words, this means that one of the key problems facing nurse managers is how to ensure that management criteria reflect the work of nurses on the basis of professional criteria as well as financial and biological ones, or how we can ensure that management criteria make clear the specific contribution of nurses to maintaining and promoting the health of the population.

3. How can we establish links between care and management so that ethical work is not just a personal issue for the individual professional?

This requires us to move from centralized, hierarchical organizations to decentralized, flexible, adaptable ones with the following characteristics:

- Professionals should have sufficient autonomy and control over their work to allow them to exercise their profession within their range of competencies.

- Decision-making powers should be delegated to unit and service nurses, thereby bringing decision-making closer to information sources, increasing participating and stimulating initiative and innovation. This helps to ensure that the centre focuses on service users.

4. What are the ethical responsibilities of care nurses and nurse managers? Can we establish links between these sets of responsibilities?

Davis and Stark (1993) argued that there is a global system of shared values based on the principles of the inviolability of life, beneficence, nonmaleficence and autonomy. While this is important for any professional, it has particular relevance for nurses. We are living in an age in which health services are subject to rationing, and this makes it particularly necessary to strengthen nursing ethics, to understand that profesional ethics covers the notion of care in its broadest sense, and to establish that the caring relationship creates a strong moral bond between the giver and receiver of care.

Nurses are the key professionals in the healthcare system because they act as mediators in the relationship between science and technology, on the one hand, and the patient on the other; in their role as care providers they have the duty of defending the patient's humanity. The challenge for the nursing profession is how to provide ethical, person-centred care which recognizes the true significance of life, health and death within organizations which are

striving to achieve efficiency and cost-effectiveness. This challenge requires nurses to relate professional values and modes of thinking with the cost-effectiveness of their services.

This is why we need nurses with a sound intellectual grounding, nurses who can combine the Art of Nursing – consisting of a passionate commitment to caring, moral and ethical commitment to the profession, advocacy of and sensitivity towards the client's feelings – with the Science of Nursing – critical thought, intellectual rigour, rational consideration, measurement and verification of facts and conclusions. Wherever she works, and whatever her level of responsibility, every nurse must respond to this challenge, establishing joint responsibility for maintaining and developing the highest possible levels of health among the population for which she cares, and showing a deep respect for everyone who benefits from her work.

4. Margarita Esteve, Director of Nursing at Mataró Hospital

"I would like to stress that, irrespective of the post she occupies, the nurse must always be guided by an ethical approach."

Before addressing the discussion questions, I would like to make a couple of observations. Firstly, when relating ethics and management we must bear in mind that addressing ethical problems in nursing practice requires health institutions to develop and promote a culture which facilitates and strengthens the ethical values of professionals and patients alike. Ethical principles must be embedded in the provision of care and should guide professional practice. Ethics is integral to what we do because it guides our treatment, care and research decisions.

Secondly, although most health organizations have developed mission and value statements setting out their ethical commitment to society, daily practice reveals the gap between theory and reality. In other words, these values do not form a guide for the care practice of the various groups of professionals working in the health system.

My contribution is based on two of the objectives of this seminar:

- to consider the contribution of nursing care to health ethics
- to identify the relationships between different management models and ethical work by nurses.

Firstly, and in relationship to care nurses, the main ethical problems are often linked to respecting and fostering patients' rights. Because the patient's health should take priority over the convenience or interests of professionals or of the institution itself, there are many situations in which the care nurse needs to act as an advocate on the patient's behalf. It is the nurse who, by creating a climate of trust and mutual respect, promotes the implementation of the patient's rights. Care nurses therefore have an important role to play in fostering and maintaining the patient's autonomy by providing information and protecting privacy.

Nursing professionals are responsible for protecting the physical and psychological privacy of the patient (including the family in care-related issues), privacy relating to caring for the patient's body and meeting his basic needs, and the privacy of the personal and health information of the patient and his family.

With regard to the patient's decision-making capacity, the nurse must ensure that information is provided which is useful to the patient in taking informed, independent decisions about his health. At the same time, caring means helping the patient to actively participate in the care process, even if his illness or health problem creates some level of dependency: in other words, ethical care offers an additional guarantee of the patient's right to participate in taking decisions. In this sense, informed consent is a useful instrument which obliges health professionals to provide information. However, we should remember that consent must be the result of information and communication, and that the consent process may not end with acceptance of the treatment or care by the patient. Patient information and the responsibility of each health professional for it require doctors and nurses to work together as a team.

We have recently seen major advances in the area of wills. Traditionally, during the course of their lives people would say what their position was with regard to suffering and death should they ever find themselves unable to take their own decision. Now, it is possible to draw up a written will which is binding on health professionals. Nurses, in the course of providing care, may play the role of facilitator in helping patients to consider the possibility of drawing up a living will, and talking about them with their families.

The second discussion issue relates to ethical questions in the management of nursing services. Nurses with management responsibilities have an important responsibility for developing a culture of ethics, establishing how to implement ethical principles in their own organization. Identifying common problematic situations, and drawing up guides and protocols to help in taking decisions and to guide behaviour is one way of doing this. This means giving institutional support for professional behaviour in conflictual situations which arise during the course of regular care. At the same time, management should establish mechanisms and provide the required resources. For example, it is not uncommon for care for people from other cultures to be a source of conflicts. Having the option of cultural mediation can be of great help in making it possible to provide ethical care. It can also be helpful to have access to different religious and spiritual leaders, should patients wish this service. The same goes for situations of alleged abuse, whether of children or of adults.

Thirdly, and with regard to the links between management and care which are vital if ethics is not just to be an issue for individual professionals, in my opinion and on the basis of my experience two of the most important tools now available to us are the establishment and implementation of a quality

programme based on the values and rights of the service user, and the creation and monitoring of ethics committees where professionals can raise doubts and seek guidance on how to deal with specific situations. Planning any project, whether institutional or relating to a specific service or group of professionals, should, in addition to technical criteria, take into account previously defined ethical principles and human rights. And, of course, this involves safeguarding the confidentiality of the patient's medical history, by implementing mechanisms such as recording access to this information by health professionals and requiring professional secrecy with regard to diagnoses and test results. In answer to the question of whether it is possible to establish ethical criteria as quality criteria, I believe that it is. Analysis of medical records makes it possible to evaluate the care process. This evaluation should include aspects relating to comfort, information supplied, privacy etc, so that care ethics is integrated into each and every clinical action. This requires prior work by the whole care team, and the assistance of management in providing support for care professionals.

Finally, I would like to stress that, irrespective of the post she may occupy, the nurse must always be guided by an ethical approach. The ethics of caring must focus on the actual care provided and requires us to recognize the differences in people's needs, taking as its starting point the context in which the conflict has arisen. The manager, in addition, must stimulate and promote compliance with ethical principles by creating discussion committees or other spaces which give participants the opportunity to reflect on their different experiences.

There is clearly a need to establish links between the responsibilities of nurse managers and the responsibilities of care nurses, by defining shared objectives, and by applying assessment indicators which foster improvements and which help to develop a language shared by all the health professionals in the health centre.

5. Rosa María López Pisa, Healthcare Centre Gavarra, Cornellà de Llobregat

"Care management in these situations would involve the incorporation into daily work of activities aimed to promote ethical attitudes and to foster the internalization of group values."

First of all, I would like to thank you for inviting me to participate in this discussion. My training is neither specific in management nor in ethics, but in care provision, which is an exceptional situation, as I am a part of primary care team. Thus the community recognizes the care we provide and identifies me with this care. Despite the difficulties involved, such recognition and identification remain one of our objectives.

According to the issues set out by Montse Busquets and the contributions of the speakers Mercedes Ferro and Núria Cuxart, I will try to set out both my own thoughts and the ideas shared during my nursing team's last clinical meeting concerning this matter. Thus I will consider the main ethical dilemmas facing primary care nurses – as clearly set out by Núria Cuxart – as well as management approaches which could facilitate individual decisions so that ethical work is not just a personal matter for professionals. These approaches, in turn, would help the incorporation of a range of values in our daily practice, which could form the basis of a group or collective ethics.

Difficult situations with an emotional impact on care professionals

Of the wide range of such situations, we focused on two: caring for terminally-ill patients or for people or families where there is a very high level of mental suffering; and working with families in which members have conflicting objectives with regard to the family member's health and well-being. What happens when nurses have to provide care in a situation in which they are emotionally "blocked"? What can the nurse do if she is able to recognize this? What can management do if the nurse is not able to recognize this situation? How does the institution plan to care for the nurse in this situation and, as a result, ensure the quality of care received by the patient? In order to resolve these and other questions arising in daily practice, ethically right attitudes are necessary to promote reflection and thinking based on ethical values at the heart of healthcare teams. Care management in these situations would involve incorporation into daily work of activities aimed to promote ethical attitudes and to foster the internalization of group values. These include the following:

- **Clinical meetings and training sessions** which include discussion of the cases' ethical issues. However, we also need to ask whether it is ethical to use actual cases when a care team is responsible for caring for the same community over a long period of time. If possible, protection of privacy and guarantees of confidentiality need to be far more rigorous.
- **Protocols** or clinical practice guides which include ethical aspects as standard, clearly setting out the steps to be taken and considering the decision-making time needed by users. We should be aware that, when ethical considerations are not taken into account in clinical meetings and are not reflected in care protocols, then the necessary decisions will probably not be taken in difficult situations due to the great difficulties encountered by individual health professionals.
- **Ethics committees** which are as accessible and as close to nurses as possible, so that they can promote reflection and deliberation on difficult questions, and the fostering of personal growth and maturity through a process of consultation and training.
- **Balint groups** or other types of group work which allow to *"care for the carers"* and thereby improve healthcare relationships.

Confidentiality and free access to information

A patient's case history is and has always been a confidential document. However, the computerization of this information has made the access easier (despite the restrictions on this), and this means that those who are responsible for establishing passwords and information access and security systems must focus their efforts to define the scope of access rights. In addition, as care professionals we must also take confidentiality into account when we share our work with students or with other colleagues for training purposes. In primary care it may well be that such students or colleagues are also members of the community cared by the teaching centre and thus they could have access to information on other members of the same catchment area who could be easily identified.

Disagreement between professionals

How can an institution's management help or facilitate the nurse when she encounters a situation of disagreement between professionals? The team working model facilitates discussion prior to the decision-making and, therefore, allows the debate and discussion on possible disagreements. In

addition, if disagreements can be presented and constructively addressed at clinical meetings and, through internal or external supervision, the outcome of their resolution may have an approach based on ethical values rather than just on the specific concerns of individual professionals or groups of professionals. By contrast, if disagreements are resolved solely on the basis of the debating skills of those involved or if there is not even any debate because the views of the dominant professional group always prevail, there is no guarantee that the care provided is based on an integrated, high-quality management of the patient based on a satisfactory ethical approach, for which all care professionals take shared responsibility.

Another sort of disagreement between professionals is that which occurs when we share our duties with another professional who takes decisions without taking into account the specific situation of the population being cared for, and has an approach which is at odds with the consensus position arrived at by the team. Even more serious is where this approach leads to inappropriate or relatively harmful practice for the patient. What position can a nurse take in such situations? What is the meaning of caring when the main decisions are taken by another nurse? How can the institution anticipate and deal with such situations without getting to the point where the patient makes a legal complaint? Again, training sessions, using discussion of cases, external supervision, the inclusion of ethical values in the discussion, the existence of clinical protocols which take account of these values, and advice from ethics committees are the basis upon which the most ethically appropriate care can be assured, with the clear commitment of the institution responsible for overall care and treatment of patients.

Coordination and integration of resources

There are other elements which appear only to be related to the management of resources and which, however, also involve ethical aspects of caring and relate to the principles of nonmaleficence and justice. These include conflicts which arise from poor coordination and integration of resources. One example of this would be performing analytical tests twice on the same patient because the tests have been requested by different centres where the patient is treated. Is it necessary and fair that these tests are repeated when it might be possible to integrate the information, coordinate the resources and perform the test in the most appropriate centre?

Institutional or centre management also influences professional's time management by promoting some activities at the expense of others, or by prioritizing care for some patients rather than others. From an ethical point of view, time management training for professionals is essential, as time represents a limited resource and we need to ensure that there is a positive, balanced correlation between the care function and the working day and quality care. Both professionals and the institution need to be closely involved with achieving this objective.

Prioritizing activities

We should also consider to what degree the model of Management by Objectives (MBO) may have a positive or negative influence on work quality by prioritizing certain areas which are subject to audit, assessment and perhaps remuneration, instead of others which may actually be the most appropriate for patients. It is therefore necessary to encourage and strengthen individual ethical attitudes to ensure that the most intimate caring activities are not affected by any pressures originating in the system of management by objectives. An alternative management system could be to favour more flexible evaluation models in which the weight given to the achievement of objectives would depend on the cases assessed.

The care function and the teaching function

It is also important to consider the difficulties which may arise when carers have to perform both our care and teaching duties without having specific time allocated to it, but having significant additional responsibilities. This dual role requires additional personal effort and also means that we have to share our attention between the patient and the student, who may well have diverging interests. Assuming that nursing professionals are striving to achieve this double objective, the question is how we can "care for" the student so that his/her learning experience is effective, based on positive experiences and avoiding as many future errors as possible. What teaching tools does the nurse tutor have at her disposal to ensure the achievement of objectives? One response would be to continue developing the exchanges and coordination which have already been initiated between the nursing schools and primary care centres, with the objective of improving the quality of teaching and to supporting the tutorial role that nurses exert on future health professionals.

In summary, I believe that, achieving a real internalization of ethical values in clinical and teaching practice and care management, and the changing of these values from an individual issue to a collective outlook, the institutions need to go through a philosophical and organizational process whose fundamental concern is to improve the quality of care provided and to promote the well-being of the population cared for.

6. Núria Gorchs, Executive Secretary of the Centre for Ageing Studies of Catalonia

"Managing nursing care always involves managing people's needs and abilities …"

My contribution is based on my experience in the fields of palliative care, geriatrics and dementia, in a health and social care centre which is part of the Santa Creu Hospital in Vic. For us, interdisciplinary team working is absolutely vital if we are to achieve the specific care objectives which support our central objective of promoting the quality of life of patients and their families.

I would like to start with some observations about the framework within which nursing care operates:

1. The current health system, as Núria Cuxart has explained so well, is almost exclusively oriented towards illness, within a biophysical paradigm. This system provides fragmented care which does not respond to the needs of people with chronic health problems; it is organized around acute episodes of illness, with only sporadic follow-up, in which the patient and his family have a passive role, and both prevention and low-cost effective treatments are under-used.[1,2] This achieves very few lasting results for people who suffer from chronic illness, there is little integration of the different levels of care and it does not provide an appropriate response to dependency. There are existing social and health policy options which should be applied.[3]
2. The material with which we work – people – and the purpose of our work – helping people to achieve the highest quality of life possible. Quality of life, understood as "achieving harmony between reality and expectations, maintaining our dignity and our possibilities for personal and social development,"[4] requires a multidisciplinary analysis and an interdisciplinary intervention which cannot be limited to doctors and nurses. We therefore need a clearly defined methodology for cooperative, interdependent team working, and a truly interdisciplinary approach.
3. The "therapeutic encounter": each moment and situation of care is unique and unrepeatable. This is why care processes, procedures and standards must be clearly defined, while at the same time each health professional must be able to respond to individual patients and settings.

Managing nursing care always involves managing people's needs and abilities, and for this reason both the multidimensional analysis and the proposed action

to be taken require both the active participation of nurses and also the close cooperation of others such as auxiliaries and geriatric care professionals.

Ethical issues faced by nurses in their daily work

- **Information.** Whether or not to provide information about the disease process. The main problem occurs when there is no consensus within the team and, above all, where there is no expectation of recovery.
- **The active participation of the patient and his family.** The involvement of patients and their families in "self-care". How can we develop the principle of respecting the patient's autonomy and help him to care for himself or help his family to contribute towards this process? How can we help patients and families to prepare for a better future? Both patients and families will need time to adapt to changes, such as situations of dependency, and care must include both emotional care and practical education. In other words, it should focus on a person's daily life, their motivation, and so on.
- **Resources.** Given the low nurse: patient ratios and the burgeoning administrative workload, particularly in the fields of social health care and residential care, how can the principles of justice and nonmaleficence coexist? Mistreatment, inadequate treatment or unpleasant treatment can often have a lot to do with the resources each professional has at her disposal. I do not say this to excuse poor practice but rather to stress the need for greater awareness-raising, education and training for health professionals and all those who have contact with patients and their families.[5]
- **Decision-making.** Problems arise when the decision-making process is based more on scientific evidence than on the need to respect the decisions of family members: in other words, when the principle of beneficence is given priority over the principle of autonomy. The balance is a difficult one to achieve, and the problems are often a result of the system within which we work, as discussed above, and a lack of training and experience in working from the patient's perspective.
- **Team working.** If the overall outcome of a care process depends on my contribution, how can we understand the principles of justice, equity, solidarity and so on within the team of there is such a range of employment conditions? Not just between doctors and nurses, but also between nurses and auxiliaries or care workers, between social workers and psychologists, and so on.

Ethical problems faced by nurse managers:

- Consistency of agreed, described and assigned values, with real values.
- Financial difficulties in implementing the plans needed to deliver care.
- Coexistence of different levels of competency and different levels of results.

Possible links between care and management for joint ethical working

It is very useful to have written documentation, with clearly defined processes, standards, procedures and guidelines for how to act in ethically complex or risky situations. There should also be working groups to improve and review this documentation in order to keep it up to date and arrive at a consensus.

At the same time, management faces the challenge of taking a proactive approach and of demonstrating that other organizational approaches are feasible and can deliver better results: for example, having a specialist nurse provide support and continuity in the home reduces mortality and morbidity in people suffering from heart failure.[6]

Inclusion of ethical criteria as quality criteria

As the Nursing Ethics Code of the Official College of Nursing of Barcelona indicates, the development of ethical criteria as quality criteria requires health professionals to possess a range of knowledge, mental qualities and technical skills if they are to fulfill their responsibilities. In addition, professional malpractice must be penalized, and we must remember that the nurse should work exclusively for the benefit of the patient's health.

Furthermore, as Mercedes Ferro explained so well, the five basic principles are applicable both to management and to care. It is probably in palliative care and caring for elderly people at the end of their lives that the application of these principles is most urgent.[7]

Shared responsibilities between care nurses and nurse managers?

One major responsibility is to put on record the care which the patient and his family should receive and to which they are entitled. I believe that this is a shared responsibility, which requires a proactive approach based on mutual respect between professionals, but where we also need to report failure to meet

the obligations. Standardizing care is difficult when we are dealing with people's life quality, and when care is provided in "unique therapeutic encounters". However, we should still try to define it as precisely as possible and then use this as a starting point for taking into account the individuality of the carer, the family, the patient and the therapeutic encounter.

Another responsibility is that of participating in health policy debates and strategies, and keeping up to date with colleagues' contributions and publications on these issues. Finally, we must look for new formulas for managing the system so that we can help patients and their families, and ensure that we are doing things as well as possible.

References:

1. WHO. WHO doc. No. WHO/NMC/CCH/02.01. *Innovative care for chronic conditions: Building Blocks for Action: global report.* 2002 www.who.int/chronic_conditions/en/
2. Bodenheimer T, Wagner EH, Grumbach K. Improving primary care for patients with chronic illness. *JAMA* 2002;288(14):1775-1779
3. *Llibre blanc de la Gent Gran amb Dependència: repensar l'atenció a la gent gran amb dependencia: 45 propostes de millora i 10 recomanacions.* Generalitat de Catalunya. Departament de Benestar Social. October 2002
4. Sobre el envejecimiento. Editorial *Rev ROL enf* 2004; 27(4): 5
5. Documento de la Asamblea Mundial del envejecimiento. Voces ausentes. Opiniones de personas mayores sobre abuso y maltrato al mayor. World Health Organization. INPEA (Red Internacional para la Prevención del maltrato al anciano). Geneva. *Rev Esp Geriatr Gerontol* 2002;37(6):319-331.
6. Blue L, Lang E, McMurray JJV, Davie AP, McDonagh TA, Murdoch DR, Petrie MG, Connolly E, Norrie J, Round CE, Ford I, Morrison CE. Randomised controlled trial of specialist nurse intervention in heart failure. *BMJ*, 2001;323:715-718.
7. *Better palliative care for older people.* Ed. Davies E, Higginson J. WHO Europe. 2004.

7. Luisa González, Director of Nursing at the Hospital Clínic i Provincial in Barcelona

"Both care nurses and nurse managers have the shared aim of maintaining and promoting care for the person, and of helping people understand the specific social mission of nursing, and the usefulness and importance of the service our profession provides to society."

What are the ethical problems faced by nurses in their daily work caring for patients, service users and their families?

I agree with the main points made by both speakers and, with reference to this first question, Núria Cuxart has identified the most common ethical problems encountered by nurses in the clinical setting. Many of these problems go beyond the responsibilities of individual nurses.

Given the importance of such ethical-professional cases in carrying out our daily activities, I believe that it is vital for the managers of nursing services to promote awareness and training with regard to the ethical obligations of nurses. However, if we just view ethical issues as an individual matter for each nurse then, as Professor Cortina (1998) argues, "it may be that a group of professionals wants to work in accordance with the requirements of the profession but that this is made impossible by the structures of the hospital organization in which they work or the public health institution within whose remit they fall." This is why I believe that the ethics of caring should not just be discussed from the individual perspective of each nurse, but should also be considered from the perspective of the ethics of organizations and health institutions.

What ethical problems are faced by nurse managers?

It is more difficult to talk about management, but the ethical problems and questions faced by the nursing profession as a whole are also those encountered when managing nursing activities. Of course, management also has to take account of financial criteria and resource optimization issues which affect society as a whole and not just health service users. In addition, to expand upon an observation quoted by one of the speakers, in principle I believe that it is impossible to contemplate the management of nursing care in the public sector which neglects or deliberately flouts ethical criteria on strictly financial grounds. The greatest ethical problem facing nurse managers is,

therefore, that of how to reconcile material and budgetary restraints with the development of nursing practice which reflects both professional principles and the goals set by health institutions.

How can we establish links between care and management so that ethical work is not just a personal issue for the individual professional?

Health institutions should have a clear, well-publicized ethical-professional framework, based on broad principles which are valid for all health professionals, and should translate these principles, rules and guidelines into operating rules in order both to maintain permanent ethical standards and, above all, to analyze and address issues which arise in specific cases or settings. We also need to consider the option of establishing stable mechanisms such as hospital or multi-institutional committees to facilitate regular exchanges between different professional groups or services with regard to specific issues in professional ethics. These, of course, should not detract from or interfere with systems and procedures which already exist to regulate and deal with any decisions which need to be taken in order to respond to specific disputes which may arise from care activities.

Can we include ethical criteria as measures of quality or high standards in the management of care units and health institutions?

Ethical-professional requirements encompass quality criteria and, indeed, this is probably one of the key elements of the duties of health professionals. As in any other professional activity, a commitment to quality is, in itself, a basic element of professional ethics without which an ethical approach is not possible. In the case of health, which affects one of the individual's basic rights and is fundamental to people's well-being and self-esteem, quality is even more important and involves criteria of competency, professional skill, human care, personal integrity and moral responsibility.

What are the ethical responsibilities of care nurses and nurse managers? Can we establish links between these sets of responsibilities?

Both care nurses and nurse managers share the aim of maintaining and promoting care, and of helping people to understand the specific social mission of nursing and the usefulness and importance of the service our profession provides to society. Taking this as our starting point I believe that we need to talk not just about ethical responsibilities from a professional,

institutional and personal perspective, but also from the perspective of how nurse managers and care nurses take decisions.

Today's decision-making process is very complex and requires an ethical approach. Often, these decisions are not based on nursing models and values but are instead based on those of other health disciplines. In this situation, there are bound to be differences of opinion and of approach with regard to the management and care model. I should also add that, in my opinion, it is morally unsustainable to apply professional and management models which create expectations among patients and care staff alike which cannot then be met.

8. Ramon Bayés, Professor of Basic Psychology at the Autonomous University of Barcelona

"I personally consider that care (or to put it another way, promoting the patient's quality of life) can be good, acceptable or poor, and that monitoring its quality should be one of the priorities of managers in order to guarantee the best possible hospital care."

The need for and the importance of evaluating care as part of efficient management

Both the two papers and many of the contributions of panel members have agreed in identifying care as the central axis of the nursing profession. I would like to draw people's attention to the following issues:

1) Even if one agrees with the notion that care is the central axis of the nursing profession, we should also remember that care is not provided exclusively by nurses, any more than curative medicine is the exclusive domain of doctors. In an acute process, the main objective of all the members of the health team – whether doctors, nurses or members of another health profession – is to cure the patient. By the same token, during the dying process, all the members of the team – nurses, doctors, social workers or psychologists – share the basic objective of caring for the patient. This is reflected, for example, in the fact that units which care for patients at the end of their lives are called palliative care units.

2) Just as there is efficient and inefficient curative practice, so there can be efficient and inefficient caring practice.[1,2] For this reason it is important – however difficult and complex this may be – to create and apply care evaluation indicators and instruments which are simple, ethical, reliable and valid. And these indicators and the ongoing effect of systematically applying them should form a key part of the information provided to managers for use in the decision-making process.

3) In my opinion, rather than being based on the needs and characteristics of each profession, perhaps it would be better – as Núria Gorchs has suggested – if care issues focused on the problem of caring for patients, who are after all the reason why health professionals exist. While it is true that care may involve nurses more directly, and in this sense it would be logical for them to give rise to more research and training initiatives in this area, doctors and other health professionals are also involved in the caring process. This is why I believe that

an interdisciplinary approach probably provides the best starting point in the search for the most appropriate solutions.

4) One of the key components of care is good communication with the patient. However, while it is certainly true that it is often the nurse who is the recipient of confidences and requests for information, and the channel for expressions of emotion, we should not forget that other professional groups are equally affected.[3] This is why, for example, Spanish Act of Parliament 41/2002 of 14 November[4] which defines the rights of patients as the fundamental basis of clinical and care relationships applies to all health professionals. And a report issued this year by the United State's Institute of Medicine[5] recommends that doctors receive social, psychological and behavioural training before, during and after their university studies, with an emphasis on doctor–patient communication and the importance of psychosomatic interactions.

In summary, I personally consider that care (or to put it another way, promoting the patient's quality of life) can be good, acceptable or poor, and that monitoring its quality should be one of the priorities of managers in order to guarantee the best possible hospital care. I also believe that knowledge of all the factors which have an influence on the quality of care is not only of interest to nurses but rather that their research and management are part of the resources of the entire health care team. Care, even when it represents a greater input of time from the nursing profession, is by its very nature – as Victoria Camps has suggested – a social good and its implementation is the fruit of an interdisciplinary effort.

References:

1. Bayés R, Morera M. El punto de vista del paciente en la práctica clínica hospitalaria. *Med Clin* (Barc) 2000; 115 (4): 141-4.
2. Jovell AJ, Navarro MD, Salvatierra Y, Cirera M, Artells J.J. *Necesidad y demanda del paciente oncológico.* Barcelona: FUNDSIS; 2003.
3. Arranz P, Barbero J, Barreto P, Bayés R. *Intervención emocional en cuidados paliativos. Modelo y protocolos.* Barcelona: Ariel; 2003.
4. Act 41/2002, 14 November, Organic Law Regulating Patient Autonomy. *B.O.E.* 15 November 2002, 40126-32.
5. *The Lancet* (2004). The soft science of medicine. Autor, 363, 1247.

9. Victoria Camps, President of the Víctor Grífols i Lucas Foundation

"Just as ethics cannot simply be reduced to the law, and without individual acceptance and commitment to them rules and guidelines are useless, by the same token it is difficult for a personal and professional ethical project to be successful if it is not accompanied by an organizational project."

One of the most widely discussed issues in this debate has been society's inadequate recognition of care. Or, as Núria Cuxart explained, while care activities meet society's expectations with regard to the need for care, the promotion of care has not produced significant changes. With reference to perhaps the most noticeable of these developments, while medicine remains anchored within the biomedical paradigm, daily practice calls for a "person-centred" model.

I wonder whether the difficulty of changing paradigm and establishing the new model arises from a division of labour and specialization which assigns caring to nurses and curing to doctors in far too radical a way. In this model, the doctor's job is to diagnose the patient's state and prescribe the best treatment with the aim of curing his suffering, while nurses must endeavour to perform a series of far more complex tasks which address the patient as a person, and which can be summarized by the word "care".

I should also add that, in my opinion, this excessive distinction between the tasks of the doctor and those of the nurse is now very out of date. Let us compare this notion with the following from the seminal text on the subject, "The goals of medicine", published by the Hastings Center in 1996. According to this text, one of the goals of medicine, in a society as complex as our own, should be "to look after and cure the sick, and to care for those who cannot be cured." Scientific and technical progress, and one of the consequences of such progress – the prolongation of human life – lead inexorably to situations where caring replaces curing. As Ramon Bayés explained earlier, while there is a stage during the treatment of a patient where curing is the main focus of health practice, we also reach a stage where curing is no longer possible and, as the Hastings Center document indicates, we must concentrate on caring.

I believe that this focus on caring involves all health professionals, whether doctors or nurses. This should be the issue, but this does not happen in practice due to professional inertia, the demands of how work is divided, and even, I

should be so bold as to say, due to professional corporativism: "Caring is the domain of nurses, while curing is the domain of doctors." I believe that it is precisely this division with regard to caring (which is an increasingly fundamental part of the treatment received by patients) that is one of the features which helps ensure that care receives scant social recognition and is not a driver of significant change in the health system. Instead, it continues to be viewed as a secondary activity, performed by people who belong to a low-status professional group, and only when the real objective – curing – is no longer possible. It has already been stated in this seminar that ethics consists of giving value to interpersonal relationships, and of caring directly for the person. In the clinical relationship this value is expressed through clear communication which builds the patient's feelings of trust and confidence. The only way of creating this added value which is such a fundamental part of care is if the health professional – whether nurse or doctor – is prepared to "waste time" with the patient. After all, what else is care other than attending to the unique, individual and personal situation of each patient? This task should not be the exclusive responsibility of the nurse, but instead doctors must also participate in it.

This brings me to one final point regarding the question asked by the chairperson of the seminar, Montse Busquets, about the links we need to establish between care and nursing management. During the debate, Mercedes Ferro stressed the fact that ethics is one of the obligations of any nursing professional. I agree that ethics is, ultimately, an issue of attitudes, of duties which have been internalized and accepted by the person, a question of professional responsibility. However, just as ethics cannot simply be reduced to the law, and without individual acceptance and commitment to them rules and guidelines and useless, by the same token it is difficult for a personal and professional ethical project to be successful if it is not accompanied by an organizational project. It is now common to talk of organizational ethics and of the social responsibility of companies. The aim of is not to exempt the individual of such responsibilities in order to transfer them to the organization. Instead, it is an attempt to make it clear that in order for ethical attitudes to take root and be consolidated, what one might refer to as an "ethical climate" must be created. While it is the job of individuals to create this climate, it also has to be promoted by the organization itself. This, in my opinion, is the link which needs to exist between care and management.

10. Maria Gasull, Lecturer at the School of Nursing of Sant Pau Hospital in Barcelona

"I would like to stress that, when we talk of nursing care, this has traditionally referred to two things: caring in the sense of applying specialist, technical treatment, and caring in the sense of concerning oneself with the sick person by showing a deep interest in him as a unique individual."

In their papers, the two speakers have offered an analysis of the situation in nursing care management. I share many of their opinions, but given the complexity of the subject there are a few issues I would like to expand upon. In particular, there are three observations I would like to make:

Firstly, I would like to stress that, when we talk of nursing care, this has traditionally referred to two things: caring in the sense of applying specialist, technical treatment, and caring in the sense of concerning oneself with the sick person by showing a deep interest in him as a unique individual. This twin conception continues to be relevant. This is because, if we view care as consisting solely of treatment, then it is restricted to being a collection of techniques which are applied to the person's physical body. This is the biomedical or biological model in which there is no need to establish any real relationship between the two people involved. If we introduce into this model a concern for the person, whether sick or well, and for his needs, then caring for the patient entails caring for the whole person. Indeed, we can state that, without a human relationship, care cannot occur.

Human relationships are very complex, and in order to analyze them from an ethical standpoint we must take account of all the factors that affect them. In every relationship emotions and reason are interlinked, and when people act they do so as an integrated whole, using both their emotional and their rational faculties. As a result, human behaviour cannot be separated out into rational and irrational components. A truly caring attitude by nurses depends on the use both of intellectual discernment and of nurses' emotional and intuitive skills in order to respond to the patient's care needs. This emotional sensibility, together with intellectual discernment, provides the basis of truly integrated care. The caring attitude has major ethical implications, and nursing ethics must be built not only on ethical principles but also on the ethics of virtue.

Secondly, the moral significance of the care provided to patients in hospitals, through other healthcare structures or in their homes, did not receive due attention from ethicists until the 1980s. It was in this decade that nurses,

ethicists and philosophers, following Guilligan and others, created a moral theory known as the ethics of caring. This is why the subject of today's seminar is a new one and why we must strive to defend the importance of providing people with high-quality care.

I would also like to make the point that, in a society where scientific and technological development has had so much influence, the importance of care goes unrecognized, and that, as Núria Cuxart has said, this care is absolutely vital but unfortunately is also "invisible". The financial pressures which have led to a massive restructuring of healthcare systems are making it more difficult to provide people with all-round care, as can be seen in the nursing care provided in acute hospitals. In these institutions, the combination of technical complexity with very short stays are an obstacle to the establishment of a caring relationship between nurse and patient. In units caring for people with chronic illnesses, the scarcity of care staff and qualified nurses makes the provision of care difficult. For all of these reasons we need to encourage ethical debate which considers the problems of fair distribution in general and which pays particular attention to the question of how scarce resources should be distributed, bearing in mind that caring is one of our basic needs in life and cannot be restricted.

Thirdly, the speakers talked about the issues of responsibility and excellence in care management. Responsibility is intrinsic to human nature, and this is why people always seek to justify their actions. We do this both to ourselves (ethical responsibility) and to others who ask us to explain our actions (legal responsibility). As professionals, the same thing happens, and we cannot limit ourselves to legal responsibility but must also respond at an ethical level, what Diego Gracia refers to as criteria of "quality" and "excellence" or an ethics of maximums which strives for perfection in care and for the happiness of every patient, in contrast with an ethics of minimums which can be required of people, and which is expressed through the law. Being professionally responsible means taking moral decisions which not only comply with the law and with an ethics of minimums but which also promotes the happiness and well-being of everyone who is cared for.

This ethics of maximums requires a thorough analysis of the care situation and, as we have already mentioned, must be grounded in nurses' ethical duty of care and all that this implies, drawing on the ethics of virtue. Existing codes of professional ethics do not provide a sufficient basis as they do not take into account all of the ethical problems which may arise during the course of a nurse's work. Lidia Feitó explains that a code of professional ethics contains the

minimum obligations and is concerned with duties: as a result, it establishes what any professional group regards as the basic requirements in exercising its profession. This code of professional ethics corresponds to what we have termed the ethics of minimums, which indicates the minimum standards tolerable but not all those actions which a professional should perform according to an ethics of maximums, which more closely reflects the sense of responsibility which promotes the happiness and well-being of those being cared for.

11. Judith Gispert, Health and Hygiene Manager at the Albà Foundation in Barcelona

"Creating a shared institutional project which includes ethical criteria for nursing and care values means developing a set of specific care quality policies which should pervade the actions of everyone who works at the institution."

My contribution to the seminar is based on my professional experience in a care home for elderly people. Looking after the elderly on a daily basis brings us up against ethical problems which relate primarily to caring for basic needs for the maintenance of life. The dependency of those living in care homes with regard to activities of daily living means that care must be considered very rigorously in order to ensure respect for the person's well-being and to grant them as much autonomy as possible. Team working in order to create a consensus around care philosophies and ways of working, while always necessary, is absolutely vital in such situations. The care home is a place where people live and this means that as a care resource it must meet all of the residents' needs.

I would like to stress the importance of communication between nurse managers and care nurses, so that possible differences, instead of being a source of conflicts, can contribute positively to the taking of decisions regarding the care required by elderly people. We need to be able to draw up agreed working guidelines while also giving the care nurses enough autonomy to allow them to provide individual care for each elderly person in line with his or her needs. There should be no conflict between care protocols and individualized planning of care, and detailed evaluation of each person, his resources, family, views, wishes, habits, health problems and so on must be taken into account.

Creating a shared institutional project which includes ethical criteria for nursing and care values means developing a set of specific care quality policies which should pervade the actions of everyone who works at the institution. The project is the responsibility of both nurse managers and care nurses. For this reason, quality and ethics are completely intertwined and one is not possible without the other.

We must be able to translate care values into criteria for measuring results, both from an organizational perspective and in direct care. If everyone, whatever area they work in, shares responsibility then we can join our efforts in the common task of caring in a consistent, respectful and tolerant manner.

12. Clara Gomis Bofill, Lecturer at the Faculty of Psychology and Educational Science of Ramon Llull University

"I believe that the key to effective, ethical management lies in the ability to trust and to build trust."

Recognizing value and building trust

Recent years have seen big changes as a result of advances in the health sciences, technical progress, changes in health resources, and better training of health professionals. However, this progress can only have a full impact when it works in harmony with the changes to the social conception of health which have gradually been gathering strength at the same time: an integrated conception of health and the person.

This new notion of what health is moves away from the idea that health is simply the absence of illness, towards the deeper, more precise and more demanding concept which stresses the positive and all-embracing nature of a healthy life and the active role which every individual has to play in achieving this; that is, a concept of health which focuses on 'being' rather than on 'having' and on a way of living which promotes a harmonious balance between the different dimensions of the human being (biological, psychological, social and spiritual). This is why we need health care in which multi-disciplinary teams of doctors, nurses, psychologists, social workers, educators and spiritual counsellors all work together. For nursing professionals, this means that we need to care for the healthy development of the person and his body in order to enable him to lead a full life characterized by autonomy, solidarity and enjoyment; a life which allows every human being and their family to live as peacefully as possible in the circumstances in which they find themselves, despite illness, physical or mental limitations, grief and pain.

Nursing professionals have the job of curing and caring for people at the most vulnerable times of their lives – birth, illness, old age and death – and of actively promoting their health and well-being. Within the health care setting, our job is to offer constant, intimate care. Our fundamental value lies in the quality of our care, but also in the quality of our presence. For this reason, nursing professionals play a vital role in promoting the person's sense of his dignity when his body is failing him and when the patient may have withdrawn into himself and feel emotionally insecure and isolated from his surroundings. The proximity and continuity of nursing care means that nurses are best

placed to pick up and respond to the most subtle and varied requests for help, requests which are sometimes expressed quietly and at other times angrily, because patients (by definition in a position of need) often do not know how to ask in any other way. Nurses who approach their work in a spirit of generosity and respect, who show a caring attitude, and who have the training the job requires, are able to perceive and respond to these demands: as a result, they may decide to cure wounds and relieve physical pain or discomfort, but they will also become somebody to whom patients can turn amid the confusion, disorientation and loneliness which they may be feeling. Patients who are overwhelmed by pain, the mental patient who is lost in his own alienation, the dying patient in his bed, the first-time mother who has just given birth, the elderly person who can barely move ... all can recognize a respectful gesture, a friendly word, an affectionate glance, an attentive ear, gentle hands, a thorough approach, a smile, an aura of tranquility.

The nurse manager knows that this is the aim – and the value – of the team she directs: to offer a health service of the highest standards which is committed to curing and caring, to attending to all of those (patients, nurses and professional groups) in her charge. Her proximity to the day-to-day realities and the specific conditions which provide the setting for her work mean that the nurse manager is also aware of the financial, organizational and human difficulties which this entails: routines, lack of time, pressure, staff: patient ratios, burn-out, demotivation, exhaustion. Despite this, the nurse manager must create the necessary conditions, take the appropriate decisions, and take the right approach, to ensure that the whole team, of which the nurse manager is a member, is able to achieve the shared goal of providing excellent care for the patient. And precisely because the manager is aware both of values and problems, it is her job to manage her team of nurses with a combination of action and care, direction and concern, leadership and listening.

I believe that the key to effective, ethical management lies in the ability to trust and to create trust. This means having trust in one's team and in the unique, specific contribution which every member of it can make, in the skills and talents of each individual – even when the individual concerned may be unaware of these due to fear, insecurity, lack of drive and ambition, or lack of training. In other words, managers must have even more trust in their team members and in their potential than these have in themselves. Managers must help team members to discover their potential, to find their motivation, to develop their talents, and to deploy these without fear. They must help them to

feel like better professionals and like better people. They must help them to feel confident that good work will be appreciated, that their opinions will be taken into consideration as far as is possible, that dialogue will create realistic expectations and help to resolve disagreements. They must make team members feel, in sum, that they can count on the training and support they need to perform their professional duties.

Of course, even so there will be all sorts of people within the team. There will be those who want to continuously develop their skills and knowledge and to share these with others; those who are satisfied with the job of applying effective cures on a daily basis; those who need flexibility to allow them to combine workplace and family commitments without feeling forced to choose between the two; and those who simply want to get through the day without too much hassle and without expending too much energy. But while we cannot expect the same from everyone, we can expect something of everyone. Positive attitudes are contagious, and optimism and hope have a tendency to spread. The nurse manager can and must provide a model of professionalism and human quality in care, the same qualities with which nurses should approach their patients. She can achieve this if, in addition to trusting in and responding to the diversity of her team, she shows herself to be honest and inspires others to trust her. Without such trust, when the manager organizes, decides, shows or delegates she is exercising arbitrary authoritarian power, not leadership. Curing and caring for the health of other people, responding to their vulnerability and to the richness of their humanity, are the contribution, the real meaning, the added value which nurses bring to health care. Nurse managers must be convinced of the value of this complex task, must act as guarantors and promoters, leaders and facilitators, not just within the nursing team but also among the other managers within whom they work and in society as a whole.

13. María Francisca Jiménez, Lecturer at the School of Nursing of the Rovira i Virgili University

"Both nurse managers and care nurses must work on an equal basis by promoting communication in order to strengthen the human qualities we all possess."

The scope of care management and institutional management means that both are highly complex activities. They focus on human beings in different settings: the first on patients suffering from illness, and the second on health professionals within an institution. Given that management is an activity which is carried out by people and which is aimed at people and teams of people, from my experience as a care nurse and a teacher I believe that there are four perspectives from which the activity of management can be viewed:

1. Oneself.
2. In relation to others.
3. In the performance of nursing duties.
4. In relation to the institution.

Oneself

The analysis of oneself includes self-knowledge, self-care and self-development. Self-knowledge is fundamental; it means knowing what we think and feel with regard to specific situations or people, and why; it means knowing why we take the decisions we do; and it means knowing what we want and what we do to achieve this. In other words, self-knowledge involves identifying and analyzing the basic values which underlie our actions. Self-knowledge can be a vital source of information about the processes of health and illness which we all experience in the course of our lives. Training in clarifying our own values can allow us to help others in the same situation.

Knowing oneself also entails caring for oneself. Self-care is a vital element of doing such a demanding job. We must find time for ourselves: for training, for relationships, etc. If, as professionals, we don't know how to look after ourselves then it will be more difficult for us to look after others. Self-development also plays a key role in our analysis of ourselves. It covers all those changes we need to make to ensure that our daily work remains focused, from removing unnecessary complications from our lives to learning to delegate better or become better communicators.

It is up to us to decide how we want people to recognize us. Positive changes focus on improving human relationships, on team working, on optimism and positive thinking, on reflection, continuous improvement and satisfaction in a job well done. And, like all changes, this requires learning.

In relation to others

Both nurse managers and care nurses must work on an equal basis by promoting communication in order to strengthen the human qualities we all possess. These are qualities which we need to implement in management as they promote team working and help turn the workplace into a space characterized by respect and by personal and professional development, a place where people can learn, teach and enjoy. For example, we can learn how to facilitate decisions, promote cooperation, delegate tasks, foster group cohesion and encourage communication. Honesty and straightforwardness when dealing with people are appreciated by everyone, although they should not be confused with a lack of proper boundaries.

In the performance of nursing duties

Management should promote responsibility in order to encourage health professionals to take independent actions to develop both the patient and the nursing discipline as a whole. It is important that care nurses are familiar with and value the culture and philosophy of the institution where they work, as this helps them to be realistic and enables them both to contribute to achieving its aims and to introduce changes and improvements. For this reason, nurse managers must strive to involve the members of their care teams in their work. Being clear and objective, and recognizing the true value of things will help people to feel secure and promote team working. Taking pleasure in one's work is something we can transmit to others, and when this happens it is one of those things which are literally priceless.

In relation to the institution

Institutions and those responsible for their management need to look for mechanisms which aid communication and build links between the viewpoints of the institutions and those of health professionals in order to bring together the institution and the people working in it. I believe that it is vital to ask ourselves, "What institution am I in?", "What objectives does it have?", "What is its corporate policy?", "What do they expect of me?", "What am

I expected to contribute?" There must be some affinity between objectives and viewpoints, otherwise this process of bringing together will be a difficult one. The objectives of institutions and professionals must be similar if they are to share an ethical approach. Everyone should be familiar with the characteristics and philosophy of the centre where they work in order to analyze their own work within the institutional context. Nurse managers are a key link in the chain which joins the institution and its philosophy with the daily reality experienced by health professionals.

In conclusion, whatever the area of responsibility of each nurse – whether management, care, teaching or research – her ethical approach must be based on communication and on the establishment of relationships of trust: trust in individuals and in the human potential which we all possess. Without trust, good communication is impossible, and this creates huge problems for care management. Ethics and management go hand in hand because they share many elements with each other and with the daily work of nurses in caring for people.

14. Cristina Martínez Bueno, President of the Catalan Association of Midwives

"What lies behind us and what lies before us are tiny matters compared to what lies within us."

Ralph Waldo Emerson

1. Introduction

Addressing the issue of ethics from a non-specialist viewpoint is at once both a challenge and an opportunity for reflection. Society, and as a result health policy, are experiencing significant changes regarding the adoption of new values, our notions of health, the application of new technologies, the skills and abilities required of health professionals, the transformation of organizational care models, and the demands of health service users for greater information, participation and responsibility regarding decisions affecting their health. These developments entail a new relationship between citizens and health professionals, and they require us to work for the benefit of patients and service users, improving and maintaining our levels of skill and integrity, and justifying our actions to service users and to the profession itself. [1]

To do this we must have a perspective which allows us to balance the ethical concerns and moral freedom of the individual with the notion of health itself and the many ways in which this can be understood. We cannot have a completely static definition of health. Instead, Hernán de San Martín[2] offers us the following broad, comprehensive and non-utopian definition.

"A dynamic, relative psychobiological and social phenomenon, which varies widely in the human species, and which corresponds to a physiological, ecological and social state of equilibrium and adaptation of all the human organism's faculties with relationship to the complexity of the social environment." This concept of health contains three key elements: a subjective component (well-being), an objective one (fitness for function), and a third, psychosocial component (the social adaptation of the individual).

---

[1] Generalitat de Catalunya. Departament de Sanitat i Seguretat Social. *Llibre Blanc de les professions sanitàries a Catalunya*, Barcelona: Departament de Sanitat i Seguretat Social.; 2003.

[2] San Martín H. *La crisis Mundial de la Salud.* 2nd. Ed. Madrid: Editorial Ciencia 3;1985. p. 23.

This new concept of health is part of the wider idea of health promotion, a movement which involves not just the health sector but society as a whole. Promotion emphasizes a holistic vision of health, illness and how to intervene in them. It involves other intellectual and policy trends in today's society, in a way which is similar to how the notion of primary care has grown from being a form of care to become a whole way of thinking.

The nursing profession has a fundamental responsibility towards service users, but also towards society as a whole. Raising ethical questions is absolutely fundamental because there is rarely an ideal solution to the dilemmas which arise in the course of providing health care. As a result, we must seek to base such care on a balance of opinions, and this requires us to develop our understanding of the meaning of a basic ethical position in our professional work. This, in turn, requires us to give priority to and show particular respect for the needs and rights of the users of our services.

2. The ethics of care under debate: from impartiality to intersubjectivity

Whereas in mathematics there is usually only one correct answer which can be identified with precision, and many incorrect answers which we can eliminate, in ethics there are various solutions whose correctness depends on our underlying moral intuitions or ethical theories. As a result, what matters is not so much the correctness of a given position but rather the value of criticism, and of space for thought. Indeed, our awareness of the conflict between wishes and law, between nature and rules form the very foundation of ethics.[3]

There is what is now a classic debate between the ethics of justice and the ethics of caring, which have come into conflict as a result of the differing concepts they defend. The ethics of justice is understood as the application of abstract moral principles in which we strive for an impartiality which views people as a "generic other", and which ignores their individual characteristics. From this perspective, the aim is that people should agree on the solutions to moral problems.

In contrast, the ethics of caring is characterized by decisions which are more context-dependent. It includes a tendency to adopt the point of view of the "particular other", with all his or her peculiarities, the role of feelings, a

[3] Xandri, J. Ética, origen y horizonte. Tres al Cuarto. *Actualidad psicoanálisis y cultura* 1997; 3:27-30

concern with the specific details of the situation being judged and, given the importance of the context, an acceptance of the idea that not everyone has to agree on the solution to any given moral problem. The ethics of caring places special emphasis on a personal, individualized approach, in order to achieve moral understanding. In this sense, the ethics of caring enriches and humanizes personal contact.[4]

Adopting an ethics of caring places a responsibility on us not to be overly paternalistic towards service users, and to strive to combine care with justice, not as opposing concepts but as a combination which will lead to a professional ethics which better meets the needs of today's society.[5] One of the basic concepts in the ethics of caring is that of responsibility, understood as an awareness of the fact that one belongs to a network of relationships in which we all depend upon each other. Responsibility does not just involve not doing anything which harms the rights of others, but also entails a moral duty to act; disregarding this duty is to behave immorally.

3. The value of communication in the management of care: self-knowledge

The service user is the focus of our professional actions. One of our fundamental concerns is to foster autonomy through communication, information and helping patients to take responsibility for their own care. However, in order to get closer to the other, we must first know ourselves, and this self-knowledge can only be achieved through a long personal journey. For this reason, it is vital that there is space for emotional self-knowledge so that we are aware that the world in which we live consists not of objective things but rather of things which we perceive emotionally.[6]

Training in ethics requires us to challenge and rework our professional attitudes with the aim of bringing about personal and professional improvement in which communicational values play a vital role: closeness, intimacy, justice and loyalty are all important. Ethics or morals, as Victoria Camps explains,[7] "are no more nor less than the expression of certain feelings and attitudes, of our preferences for some forms of conduct and our disapproval of others."

---

[4] Hernán Báez R. Valores y comunicación. Ética del cuidado. *Medicina general* 2001;31:113-120.

[5] Corrales E; Baelo L; Grau C; Khalil M; Fernández M; Grijalva R. Importancia del respeto a la autonomía de la persona desde la ética del cuidado. Excelencia enfermera. *Revista científica y de divulgación* 2004; Julio.

[6] Marina JA. *Ética para náufragos.* Barcelona: Anagrama; 1995. p. 47.

[7] Camps V. *Virtudes públicas.* Madrid: Espasa Calpe 2nd. Ed.; 1993, p. 19.

Humility is a basic value which should characterize the daily work of health professionals. To quote José María Valverde,[8] this is a far more real virtue than sincerity, as it involves restraining our desire to say everything, to impose our views, and to think and act as if we are best.

The autonomy of the service user, from this perspective, becomes even more valuable and significant. At times, autonomy is not given full expression as professionals sometimes still have a latent fear of granting autonomy and thereby losing their professional role. Of course, this would be disputed in professional discourse, but if we examine our actions carefully we will still find traces of this in-built fear which places a limit on the real autonomy of the service user.

The words of Eduardo Galeano[9] may help to make us more aware of this and give us something to think about: *"If you make love you'll get AIDS, if you smoke you'll get cancer, if you eat you'll develop cholesterol, if you drink you'll have accidents, if you breathe you'll be polluted, if you walk you'll encounter violence, if you read you'll become confused, if you think you'll get worried, if you feel you'll go mad, and if you talk you'll lose your job."* This is an ethical approach in which the individual is blamed for being or failing to be healthy, without taking into account the environment, the concept of health, etc. While we are moving further away from such positions it is still worth examining and thinking about their implications from an ethical perspective.

We need to work from a perspective of autonomy, in which the person decides. The relationship with the health service user must permit and indeed promote greater closeness, developing and improving the empathy which comes from really sharing another person's emotions and putting oneself in his or her place. While this may be difficult, it is the only way to enter into personal contact. This also demands professional consistency, compassion and an ability to listen, things which we must seek in our personal resources and for which there is no instructional manual. This involves personal effort and a commitment to 'self-knowledge', adopted by Socrates as the motto of his own search for knowledge. Perhaps Socrates' error was to assume that self-knowledge could be a subject of knowledge, that human beings would be able to discover how to really live as a result of reflective inquiry.

---

[8] Martínez A; Valverde C. José María Valverde (Palabras, palabras y…silencio). Tres al Cuarto. *Actualidad psicoanálisis y cultura* 1997; 3:40.

[9] Galeano E. *EEUU en siete vistazos.* El País, 26/6/91

Finally, we should remember that in addition to knowledge of oneself, there are two further fundamental aspects: shared analysis and discussion of the values which characterize our professional practice, and supervision of our actions. Together, these allow us to take a holistic approach to the health service user. Professionalization, then, involves the elaboration and implementation of certain standards and ethical principles, accompanied by a process of constant reflection.

I will end by sharing the words of Antonio Machado with you: "*We trust that nothing of what we think will be true.*"

15. Begoña Román Maestre, Faculty of Philosophy of Catalonia, Ramon Llull University

"Because it is very difficult to identify a set of minimum standards with regard to care, the real question is how we ensure that professionals and the organization share a commitment to the patient and his circumstances."

I would like to contribute three ideas to this debate and I hope that by so doing I will indirectly answer the five discussion questions around which this seminar has been organized. I will start by focusing on the important issue of words. When we talk about management we are talking about taking decisions which affect a group, and when we talk about good management we are introducing the key concepts of quality and efficiency. Secondly, I will discuss the need to include organizational ethics in bioethical discourse. And thirdly I will consider the important issue of evaluation and measurement.

1. Quality and efficiency

When we talk about efficiency what we mean is achieving our objectives with the best use of means and resources, including both technical resources and so-called human 'resources'. If we agree that the basic objective of the nursing profession is that of caring, then our aim is to achieve this care making best possible use of the resources. We know that that does not simply mean using as many resources as possible, but rather using those which can achieve our objectives in the shortest time and at least cost. The principle of economy states that we should not create new organizations without good cause, and this is a notion that I share given that our aim is to provide better resources rather than just more resources, to provide better care rather than just more care.

However, when we talk about quality the issue becomes more complicated for two reasons.

a) Firstly, because economic discourse has become universal, and while it may be okay to recognize that efficiency also has moral value and that the principle of economy is the appropriate way of achieving an objective, it frankly smacks of cynicism to transform the means into the ends by prioritizing efficiency over quality. The upshot is that economic discourse claims a monopoly on the value of efficiency identified by the relationship between value and price, and reduces the notion of quality to nothing more than customer satisfaction or, in the case of nursing, the satisfaction of health

service users. Below, I will argue that the satisfaction of service users is a necessary but not a sufficient condition in the discourse of quality.

b) Secondly, because there is no consensus as to what caring is and I fear that if we ever arrive at such a consensus it will not be a specific, concrete consensus but rather a formal one (as must inevitably be the case) which simply cites the minimum limits of non-negligent performance. The key issue lies in the fact that caring implies that people feel they are being cared for, and this brings us face to face with the multiple, subjective, fluid and interpretable ways of feeling cared for. What we need to aspire to, then, is to identify the expectations of the person being cared for, and to identify if, despite their subjective and interpretable nature, they are well-founded; in other words, are such expectations reasonable in principle and does the organization have a realistic capacity of satisfying them.

So when we talk about quality, and this includes efficiency, we cannot ignore the issue of satisfying the expectations of others involved in providing the service: the nursing professionals and the organizations where these professionals work. This dimension of quality is more objective than the expectations of the recipients of care, which may be well- or ill-founded, or which may be possible to meet, impossible to meet today but perhaps not in the future, or absolutely impossible to meet in this organization.

Let me give you an example. If a patient asks a nurse to cure him of diabetes, it will be impossible for the care provided by this nurse to satisfy the patient's expectations and his opinion of the quality of service provided will be correspondingly low. However, anyone who is abreast of the state of knowledge about diabetes (and who better than a health professional?) should inform this service user that his expectation is clearly ill-founded and that at present there is no cure for diabetes. The task, then, is to educate the patient with regard to his expectations and to explain to him that a person with diabetes can enjoy a very high quality of life even if he remains a diabetic; that, in sum, the illness does not necessarily have to prevent the sufferer from achieving his personal aims. However, for a nurse to carry out this kind of education the organization must give her time to spend with the patient, and support her in delivering education programmes to diabetics. In this way, any nurse who has up to date knowledge of diabetes can provide information about what it is reasonable to expect when one has diabetes, and will also be able to see how the organization enables her to put this knowledge into practice.

Because it is very difficult to identify a set of minimum standards with regard to care, the real question is how we ensure that professionals and the organization share a commitment to the patient and his circumstances. Caring means recognizing the individual's autonomy and helping him to adapt to the new level of autonomy which may arise from the illness. But this agreement between professional and organizational projects will not be possible if professionals do not feel that they belong to the organization. And I would argue that this is not a question of caring for the carers, because the first challenge is to professionalize them, to facilitate the search for excellence without which neither professionals nor organizations can deliver a quality service.

2. Organizational ethics

P. Drucker, in his book *Post-Capitalist Society,* argues that organizations need to be capable of generating a sense of belonging. The challenge is to create an organization which functions like a symphony orchestra: one which is made up of skilled musicians playing a whole range of different instruments who come together within the orchestra without behaving like "stars". And to generate this sense of belonging there must be a shared project, in our case, that of caring for health service users. To achieve this, the organization must consider its style, its identity, and the shared aspirational goals with which it wishes to be identified; and it must create a participative democracy in which staff are able to benefit from professional development and ensure their continued employability.

This will not be possible without leadership, and this must be clear, conscious leadership, not leadership from behind the scenes. Ethical leadership involves accepting that in some ways this is destructive of the organization itself: people leave while the organization remains, and the good or poor health of the organization depends on the professionals who pass through it, who become professionals within it, and who take their decisions on its behalf. Furthermore, this must be proactive leadership, which does not aim merely to remedy possible errors or mistakes but which tries to establish the organization as a learning community, because all humans learn by a process of trial and error.

I think it is profoundly mistaken to confuse ethical or responsible decision-taking with the successful outcome of the decision. We always work in conditions of uncertainty, in a world which contains a range of outlooks, and

under pressure of time. Taking ethical decisions therefore means managing errors, disagreements, dilemmas and contradictions. In this way, organizational style and credibility emerge over the long term. The attraction of 'magnetic' hospitals lies in reputations built up over many years: without such a foundation, the most one can achieve is enchantment or infatuation, which may be nothing more than "a state of transitory imbecility", as the Spanish philosopher Ortega y Gasset would have it.

3. Evaluation and monitoring

My third contribution refers to the importance of evaluation. From the economist's point of view, the economy is part of the infrastructure, and he may even believe that what cannot be measured does not really exist. We must be able to measure care, because it exists, and because it is the reason why we exist, the intrinsic good of the nursing profession. And because quality cannot consist of satisfying the ill-founded opinions of misinformed or stupid service users who believe they are always right, the organization and the nursing professional must propose a way of educating all those involved in the care process with regard to their expectations, and a way of evaluating their levels of satisfaction.

One way of doing this is to ask users the following three questions, which can yield a lot of information which is useful both for evaluation and self-evaluation:

1. What are the expectations you have of me which I like? And I like them because your expectations are well-founded and as a professional working in this organization I can satisfy them.
2. What are the expectations you have of me which I dislike? And I dislike them because your expectations are ill-founded, or are well-founded but as a professional working in this organization at this time I cannot satisfy them.
3. What expectations don't you have of me but which I would like you to have? And we may discover that more than one service user doesn't expect to be cared for because he has become accustomed to neglect and disregard, and that he treats others as he has been treated: that is, badly.

If managers put these same questions to health professionals, they will uncover good reasons, moral reasons, why these professionals are not happy with their job: demotivation, and lack of guidance, support and recognition. And we may also discover a huge, untapped reserve of human capital which the

health professional would like to contribute but is unable to do so because the organization is unaware it even exists.

I will end by referring directly to the five discussion questions around which this seminar has been organized:

1. What ethical issues do nurses face in their daily work of caring for patients, service users and their families? Lots of them, none of which are easy to resolve given the pluralistic world in which we live, the urgency with which we have to work, and the often far from ideal circumstances in which care encounters may occur.
2. What ethical problems are faced by nurse managers? These should be no different from those faced by nurses, as the job of nurse managers is to facilitate the work of care nurses.
3. How can we establish links between care and management so that ethical work is not just a personal issue for the individual professional? It is not a matter of establishing links, but rather of recognizing that we are all in the same boat. The challenge is to take on the following projects at the same time: that of the individual health professionals, that of the health service users and their families, the civil project of society in general which health professionals serve, the professional project, and the organizational project.
4. Can we include ethical criteria as measures of quality or high standards in the management of care units and health institutions? Not only should it be possible, but it s the only way of doing things well.
5. What are the ethical responsibilities of care nurses and nurse managers? Can we establish links between these sets of responsibilities? Nurse managers are directly at the service of care nurses, care nurses are at the service of health service users and their families but, because of the briefness of this second relationship, the two sets of responsibilities must be interlinked, each making the other possible. And everyone must be committed to service: an organization of people at the service of people.

16. Mercè Salvat Plana, Secretary of the Catalan Nursing Association

"We should stress the nurse's role as an advocate for the patient and a defender of his rights, but we also need to stress the need for support from nurse managers."

In the course of this seminar participants have addressed a range of issues related to ethics and the management of nursing care, and we have heard both from those within the nursing profession and from professional experts who have given us a fresh perspective upon which to reflect. Following on from this discussion, I will base my own contribution on my daily experience as a care nurse.

The behaviour of the nurse while performing her duties is conditioned by:

- Professional values and the ethical code of the profession, which begin in the university. Nurses have been trained and new generations continue to be trained in ethical commitment, and this ethics continues to develop throughout the nurse's professional life. We should stress the role which both professional and scientific associations and the institutions where nurses work have to play in this.
- Personal values or personal ethics. Personal ethics are established as a result of education, family history and each individual's experiences. There may be some inconsistency between personal and professional values. This inconsistency may be the source of ethical conflict in nursing.
- The history of the profession. A historical tradition of an almost religious vocation, together with the issue of gender or of care being seen as women's work and thus undervalued, are other conditioning factors which characterize care in terms of self-denial and servility, rather than as a profession taking responsibility for its results.
- The professional settings. With this, I refer both to the institutional environment and the particular circumstances of each of the individuals being cared for. The institutional context conditions ethical behaviour because it is the immediate environment and creates the institutional climate. The ethical practice of nursing care must be supported by the institution.
- Financial management. It seems obvious that different management models entail different types of nurse–patient relationship. For example,

care will not be delivered in the same way if one is working within the framework of a management model based on people's needs, one in which relationships are commercial, one in which care has been Taylorized, etc. The latter two models will work against the provision of individualized care.

These are some of the factors which influence how nurses fulfill their professional duties. But before I finish I would like to mention another issue and focus attention on something which I believe to be extremely important on the basis of my work, my studies and my own reflections upon caring for elderly people: the social setting. Mercedes Ferro has commented on citizens' expectations and on the need for nursing organizations to be able to continuously evolve in order to keep pace with social change and the evolving needs of citizens. Apart from expectations, the social setting is the source of values which may have either a positive or a negative influence from an ethical perspective. For example, issues such as multiculturalism or ageing may pose ethical problems and dilemmas in the light of widespread social prejudices.

A study in which I recently took part, looking at the attitudes of nursing professionals to elderly people, revealed that these attitudes are generally neutral, and tend to be positive. At the same time, it showed that nurses have better knowledge of the biological aspects of ageing, while often holding misconceptions regarding the psychological and social aspects. We can conclude from this that stereotypes and mistaken beliefs still exist, together with a lack of knowledge about the meaning of ageing, and of the lives and relationships of elderly people. This can affect the specific care given, and may give rise to poor quality care, or to ageism.

The aim of this study was to detect factors which could influence people's attitudes, reinforcing positive attitudes, raising awareness of care for the elderly, and encouraging people to examine their own attitudes. Discussion of the results has generated discussion of real instances of discrimination against the elderly within health institutions and which at times gives rise to real dilemmas for nurses, dilemmas with regard to the information elderly people receive, with regard to taking decisions, and with regard to the withholding of treatment.

We should stress the nurse's role as an advocate for the patient and a defender of his rights, but we should also stress the need for support from nurse managers, a need which is strongly felt by nurses who daily face situations which call into question the ethics of care teams.

17. Jesús Sanz Villorejo, President of the National Association of Nursing Managers

"If management should be based on values, then nurse managers must strive to strengthen the value of caring as a social value, committing themselves to organizational models, spaces for care and professional attitudes which truly facilitate a user-oriented care model."

Both the title of this seminar and the focus of the discussion have invited us to consider the management of care from a range of perspectives. When I was reading the proposed discussion questions and organizing my ideas, I remembered that four and a half years ago I had made the following statement at a discussion seminar held on the same topic: "*The involvement of nursing professionals in clinical management projects is a major commitment, but it also offers the nursing profession the opportunity of achieving a model for the organization of care which makes clear to members of society the nursing profession's contribution to health care, which ensures that nursing services meet the needs and expectations of the users of health services, and at the same time contributes to the development of the nursing profession.*"[1]

In my opinion, this remains valid today. The goals are still the same, even if our perspective on them has changed. Fortunately, we have reached a stage at which values, bioethics and leadership are the keystones of any management project. We continue to witness the rapid trend towards identifying good management practice with good social practice, and this requires managers who are social leaders, experts at managing organizations, people with an ability to anticipate events, who strive for efficiency, ensuring the monitoring and evaluation of procedures. It seems clear, then, that a management culture is gradually taking root in which every management strategy must have ethics as a reference point.

At the same time, we should not forget that one of the fundamental responsibilities of management is to take decisions which affect others, and that every decision is necessarily based on certain values. "*Values play a role in every decision, even the most simple. And it is these values which define the scope for action.*"[2]

---

[1] Sanz Villorejo, Jesús. 2000. ¿Cuáles son los retos que nos planteamos ante las nuevas formas de gestión de los cuidados?. *Foro de gestión e innovación sanitaria, Gestión de los cuidados.* Madrid. 16 January 2000.

[2] Amor, José Ramón. et al .2000. *Ética y gestión sanitaria.* Serie V: Documentos de trabajo, 31. Publicaciones de la Universidad Pontificia de Comillas. Madrid. p. 15.

If management should be based on values, then nurse managers must strive to strengthen the value of caring as a social value, committing themselves to organizational models, spaces for care and professional attitudes which truly facilitate a user-oriented care model. To achieve this goal, I believe it is absolutely essential that nurses actively participate in the planning, management and implementation of all those activities which, in accordance with the WHO's "Health21: health for all" policy for Europe, contribute to achieving its main goal of *"enabling everyone to achieve their full health potential."*[3] And we must also mention the sixteenth objective, of the twenty-one established by the European Regional Office of the WHO, which talks about *"Managing for quality of care."*[4]

Starting from these two premises, we must give consideration to the role of nurse managers, with attention not so much on the specific context in which we work as on the ability to lead a group of people and a given set of projects. I therefore believe it is necessary to talk about a change in management style, with an emphasis on leadership, and I also believe that we must ask ourselves whether nurse managers need to change the ways we think. (I should clarify here that when I refer to nurse managers I include all those nursing professionals who in one way or another take on the role of nurse managers during their daily work.) Having made this clarification, I should state that, in my opinion, there is no need for a change in the way we think. I am convinced that, at the level of ideas, the vast majority of us agree that caring continues to be the raison d'etre of the profession and that we would therefore agree with Meleis and Jennings (1989) who *"argue that the management of care is based not only on administrative theories or theories taken from other disciplines, but also on concepts which are unique to the nursing discipline."*[5] However, those of us who are familiar with the daily reality of our profession must also recognize that this does not happen in practice. In other words, the shared thinking referred to is only rarely seen in professional culture, and hardly ever in society as a whole.

This fact gives rise to a number of questions. What is happening in our organizations? What is happening to our management style when it comes to

---

[3] *SALUD21. Salud para todos en el siglo XXI.* 1999. Ministerio de Sanidad y Consumo. Madrid. p.6.

[4] *Ibid.* p. 24.

[5] Kerouac, Suzanne. Pepin, Jacinthe. Ducharme, Francine. Duquette, Andre. Mayor, Francine. 1996. *El pensamiento enfermero.* Masson, S.A. Barcelona. p. 121.

managing care? How committed are health professionals to the various alternatives which exist? And these are only a few of the many questions which I am sure we could all ask.

Perhaps the problem is that the thinking we referred to above does not translate into action, and that it therefore does not influence the whole decision-making process. At the same time, we should ask ourselves what the values which guide our management function are. We should not forget, as mentioned above, that values play a role in every decision, even the most simple.

Many authors have offered guidance on how to address today's discussion questions. Professor Caterina Lloret, talking about how to manage the complexity of nursing care, asked *"How do we avoid reducing the complexity of actual institutional processes to a management which only takes account of certain types of goals, values, relationships, interventions and controls? Or, without wanting to sound pedantic, to what extent do certain business concepts together with a given set of financial settlements (distributed in accordance with particular interests) and policies which promise more than they deliver, produce a misleading institutional discourse whose contradictions are directly felt by the health professionals responsible for delivering front-line services?"*[6]

For his part, Professor Diego Gracia, talking of ethics and health management, argued that: *"the best approach is not to strive for the highest efficiency levels possible or those levels which deliver the greatest expenditure savings in absolute terms, but rather to look for maximum savings once the values and goods deemed to be important have been clearly established. In conclusion, then, we can say that economic efficiency should be at the service of values and goods, and not the other way round."*[7]

These thoughts prompt another question. Are we fulfilling our leadership role adequately, leading the care process, and basing our management on values? The leadership of care nurses carries with it the heavy responsibility of providing effective, dignified and appropriate care for patients, their families and their carers. Unless healthcare leadership focuses on this final goal, that of

---

[6] Lloret Caterina. 2003. Gestión para la complejidad en enfermería. In *La complejidad en enfermería. Profesión, gestión, formación.* Laertes S.A. de Ediciones. Barcelona. p.99.

[7] Gracia Diego. 2000. Ética de la eficiencia. In *Ética y gestión sanitaria.* Serie V: Documentos de trabajo, 31. Publicaciones de la Universidad Pontificia de Comillas. Madrid. p. 54.

improving care for patients and helping everyone in the organization to achieve its objectives, then we have to question its value.

Francine takes up this issue and argues that, *"It is desirable for there to be consistency between the values, philosophy and vision of managers, and of carers. Care nurses and managers must therefore have a common language, a single set of symbols and shared concepts."*[8]

From this perspective, nurse managers must put forward proposals and alternative approaches to management based on a nursing perspective, and which focus on *"the growth of the individual and the improvement of care settings,"*[9] seek to promote *"interaction between the person and his or her surroundings", and "aim to maintain and promote those settings which are favourable for care of the individual."*[10]

At the same time, to quote Caterina Lloret, we must generate: *"Proposals for comprehensive, flexible management which makes possible the sharing of responsibilities within teams in which relationships permit genuine cooperation and exchange. These proposals must seek to address the reductionism and the hierarchical nature of management goals and practices, and, as far as possible, to transform evaluation conducted for monitoring purposes, into formative, ongoing evaluation which is shared between institutional processes."*[11]

I should also mention that the National Association of Nursing Managers, with reference to the modification of management roles, put on record its commitment to *"facilitating"* managers capable of providing leadership in the care process.[12]

But achieving this is a lengthy job which requires the right skills, attitudes and aptitudes, which requires innovation and creativity, close involvement and, above all, *"consensus-building dialogue, which can only occur of there is a*

---

[8] Kerouac, Suzanne. Pepin, Jacinthe. Ducharme, Francine. Duquette, Andre. Mayor, Francine. 1996. *El pensamiento enfermero.* Masson, S.A. Barcelona. p. 136.

[9] *Ibid.* p. 136.

[10] *Ibid.* p. 136.

[11] Lloret Caterina. 2003. *Op. Cit.* p.101.

[12] Ande. 2000. *Gestión Clínica de los Cuidados de Enfermería.* Documento de Enfermería 3. Asociación Nacional de Directivos de Enfermería. Madrid.

real effort to reach agreement with others, to create shared aims about the best way of satisfying the various interests involved."[13] In this regard, it is worth noting that the Public Ombudsman for the Andalucia Region, in his report this year, argued specifically for dialogue between nurse managers and nursing professionals in order to solve the problems faced by the profession as a whole.

And neither should we forget the growing importance of the management role of all care staff, together with the requirement for managers to understand every aspect of healthcare.

We can conclude, then, that if we are able to continue to make process in these new endeavours then we may be able to create a management model which is recognized by nursing professionals, instead of the traditional models in which we have been perceived as providing management which is imposed from above.

[13] García-Marzá Domingo. 2004. *Ética empresarial: del diálogo a la confianza.* Editorial Trotta. Madrid. p. 140..

References:

- Amor, José Ramón. et al.2000. *Ética y gestión sanitaria.* Serie V: Documentos de trabajo, 31. Publicaciones de la Universidad Pontificia de Comillas. Madrid. p. 15.
- Costa, Miguel. López Ernesto. 1996. *Los secretos de la dirección, manual práctico para dirigir organizaciones y equipos.* Piramide. Madrid.
- Durán Escribano, Marta. Mompart García, Maria Paz. 2001. *Administración y Gestión.* Enfermería S. 21. Ediciones DAE. Madrid.
- Gill, David. Prieto, Candida. 1998. Alineando el desempeño individual con los valores organizativos. El Feedback 360° en GF Capital. *Capital Humano*, no. 11, p. 61.
- García-Marzá Domingo. 2004. *Ética empresarial: Del diálogo a la confianza.* Editorial Trotta. Madrid. p. 140.
- Gracia Diego. 2000. Ética de la eficiencia. In *Ética y gestión sanitaria.* Serie V: Documentos de trabajo, 31. Publicaciones de la Universidad Pontificia de Comillas. Madrid. p. 54.
- Kerouac, Suzanne. Pepin, Jacinthe. Ducharme, Francine. Duquette, Andre. Mayor, Francine. 1996. *El pensamiento enfermero.* Masson, S.A. Barcelona.
- Lloret Caterina. 2003. Gestión para la complejidad en enfermería. In *La complejidad en enfermería. Profesión, gestión, formación.* Laertes S.A. de Ediciones. Barcelona. p.99.
- Minzberg, Henry 1983. *La naturaleza del trabajo directivo.* Ariel. Barcelona.
- Monrás Viñas, P. 2002. Más allá del acto clínico. Rol y responsabilidades de las profesiones sanitarias en las organizaciones sanitarias modernas. *Rev. ROL.* Enf. 2002; 25 (9).
- Repullo, J.R.. Oteo, L.A. 1999. *Reformas y formación de directivos sanitarios. Administración Sanitaria.*Vol. III. No. 9. January/March1999. Madrid.
- Sanz Villorejo, Jesús. 2000. ¿Cuáles son los retos que nos planteamos ante las nuevas formas de gestión de los cuidados?. *Foro de gestión e innovación sanitaria, Gestión de los cuidados.* Madrid. 16 January 2000.
- Uriz Urzainqui, Javier. Recursos humanos; de concepto anticuado a creador principal de valor. *Harvard Deusto Business Review.* Referencia no. 1577.
- Vacas Guerrero, Mercedes. 2000. *Gestionar el proceso de cuidar; una propuesta para innovar la prestación de cuidados.* In *XXI Sesiones de Trabajo de la Asociación Española de Enfermería Docente. AEED.* Fundación MAPFRE Medicina. Madrid.
- *Gestión clínica de los cuidados de enfermería.* 1999. Asociación Nacional de Directivos de Enfermería. Federación Española de Gestión Sanitaria. Madrid.

18. Pilar Vilagrasa, Director of the Albà Foundation of Barcelona

"Because nursing research does not consist of research in the basic sciences, it has generally been neglected."

Before addressing the discussion questions, I would like to summarize the conditions which, in my opinion, act against the recognition of care in the health system and in society as a whole. The main problem, in my opinion, is that current health management structures, particularly in hospitals, are not based on caring for people, families and groups with actual or potential health problems. In Spain, it is still the case that organizational systems revolve around pathologies and costs, despite the fact that the framework within which they work, whether legal, ethical or professional, sets the goals of promoting and preserving health, and helping people to die with dignity, and sets out a vision of care which takes the whole person as its starting point. Our health institutions currently employ functional management models which are driven by efficiency objectives, are bureaucratic, reinforce the division of labour, foster quantification and a task-oriented approach, pay little attention to the quality of care, professional development or the well-being of the staff who work within the institution and, in particular, of care nurses.

Since the 1970s nurse training in Spain has been carried out in universities and this training covers the issues of management, care and research. However, because the management model used in health centres continues to be disease-based, health services in general and hospital services in particular are still organized primarily as medical services. Care focuses on the diagnosis and treatment of illness, on the process of curing. This way of organizing things means that nurses continuously face conflicts, because their profession focuses on providing care for the whole person, but the organization where they work asks them to focus on pathology. As a result, and despite changes in the content of the nursing curriculum, future nursing professionals are unable to test their theoretical knowledge during clinical training periods. This places nurses in a difficult situation:

- On the one hand, there is the nurse's commitment to society and to her profession, and a training which prepares her to take decisions with regard to care. Caring for people and families is the core of the profession, and this forms the basis of a nursing care process which includes diagnoses and specific care goals which help the healthy to protect and improve their health, and help the ill and their families to recover or to live with the illness in the healthiest possible way or, when

this is not possible, to comfort and accompany them during the process of dying.

- On the other hand, there is the difficulty of taking care decisions. Taking such care decisions is made very difficult precisely because the work is not performed within the reference framework of the nursing profession, with the result that the professional autonomy of nurses in taking decisions is very limited and operates almost exclusively at the level of the individual nurse. If management took place within a conceptual framework of caring, this would allow nurse managers and care nurses to work together to design work systems and strategies which reflected the situation of people and families, the established care goals, and the intensity of care required, applying the appropriate care techniques and available resources for each situation, in a given setting.

The contribution of care to improvements in health, the importance of dependency, the difficulties people or their families have in coping with illness, the management of resources, and the setting in which the person lives or where care is provided, are all factors which have not been properly evaluated by the health system, which are not recognized by society as a whole, and which receive little coverage in the media. In Spain, there is no systematic or institutional analysis of the results of nursing work and, because nursing research does not consist of research in the basic sciences, it has generally been neglected. Nurses themselves have conducted relatively little research, and the media have not covered their findings. However, there is now a growing body of research which provides evidence of the specific contribution nurses make to the health system. There is evidence that the efficacy of medication, surgical techniques and other treatments is quantifiably affected by the care prescribed and delivered by nurses. We now have studies evaluating the influence which professional autonomy, the nurse–patient relationship or the level of qualification of the health professionals responsible for caring has on the mortality and morbidity indices for various health problems. We need to strengthen research along these lines in Spain. The application of nursing models to the management of health services is clearly vital if we are to bring about a change in focus so that we work in a health-centred paradigm, in accordance with current health legislation and the ethical guidelines of our profession. It is not enough to talk about humanizing or personalizing care. Rather, we need nurses, who are the bearers of knowledge, experience and practice in care, to be included in the design of health service structures and in all health-related issues.

The care which nurses provide for people, families and groups is defined by concepts which are not clear and unambiguous, such as health and caring. Individual nurses, service users and families may all understand these concepts differently. At the same time, care is closely related to values and beliefs which may also differ. Finally, the context in which care is provided, whether this is a hospital, somebody's house, a primary care centre, a social and health centre, or a care home, may have a significant influence on the care provided, as may the resources available. This all means that the scale and type of ethical problems faced by nurses in their daily work vary widely. In order to ensure the best responses to these problems, nurses must have enough professional autonomy to allow them to make a thorough assessment of the situation, including their ethical viewpoint, and wherever possible they must discuss with the recipient of care with regard to the possible options and the patient's wishes, and identify the best way of helping he patient to decide.

This gives rise to three types of dilemma:

1- **Those relating to the task of attending to health needs** with the aim of supporting and maintaining the health of both the well and the sick, maintaining the highest possible level of autonomy, understood as the capacity to take decisions, the desire to take them, the strength to implement them, and the knowledge necessary to take the right decision according to the circumstances.

How can nurses care for the sick person and his family, when they spend 75% of their time implementing technical activities which derive from the medical process? How do we personalize care and provide continuity if we have not identified the nursing diagnoses relating to the medical diagnoses, or if we have not agreed on the activities needed as a result? These are two of the questions which nurses must answer on a daily basis in their clinical practice, often without the necessary help from the institutions where they work.

2- **Those relating to the right to information** throughout the entire process. The lack of communication between health professionals, above all between the doctors and nurses attending to the patient, is one of the main sources of information problems. Furthermore, because of the system's focus on the medical process, this information tends to centre on diagnosis and treatment of the illness and not on dependency or on the care required; information tends to consist of isolated events rather than being a continuous process, and the concern is usually with

obtaining acceptance rather than understanding. Information is one of the main ethical problems faced in care units, and which needs to be addressed directly by managers and nurses, even if only to ensure compliance with the legal requirement for informed consent. Nurses are closest to patients and spend most time with them, they provide treatment and administer medical prescriptions, and as a result they cannot be morally neutral with respect to information about diagnosis, prognosis and medical treatments.

What information should the nurse provide during the care process, if the patient or his family ask? When and where should this be provided? How can the patient be given information in a way which respects his privacy in a shared ward? Is it ethically correct to inform the patient during visiting hour, when there may be ten or more people with him? And what about informing the patient of a negative prognosis without any type of follow-up on the patient's needs and any doubts he may have? How should the information process be established when the patient and his family do not agree? Should nurses answer the patient or his family if they ask about the adverse effects of a medication? Should nurses allow a person to undergo surgery if they are not sure that the person has been sufficiently informed?

3- **Those deriving from the organization of the service.** As has been stressed throughout this seminar and as I myself have already mentioned, our services are currently organized on the basis of pathologies and this is a cause of ethical conflicts which I believe can be divided into two groups. Firstly, the organization of hospital units is based on the professionals who work in them, particularly doctors and nurses, rather than on the patient. Daily routines, visits and care are organized around the needs of staff, with less consideration of the individual lives and needs of patients and their families. Secondly, the planning of care units is not organized around the intensity of the nursing care required but rather around pathologies or even the number of patients. Two nurses may be responsible for a similar number of patients with similar medical diagnoses but with very different levels of dependency. There are patients who require a lot of nursing care but relatively little medical care: for example, the elderly or patients with neurological diseases. It is common for low medical dependency to be used as a basis for reducing the nurse–patient ratio, and this means that dependency and health problems which are not a direct consequence of

the initial medical diagnosis tend to be neglected, and the response to such dependency and needs tends to be medical.

If a person is unable to drink for themselves, should they be put on an intravenous drip? How do we ensure that the immobility which follows surgery does not bring respiratory or circulatory problems, when such care is not covered by the care protocol and there are therefore no staff to help with lifting the patient or to mobilize him in bed? If a patient has not slept should he be woken up at 6 in the morning to get him ready, in line with the rules of the unit, because visiting hour starts at 8? How can we include the family in the care and enable them to learn new techniques for use at home if there is no time allocated for this purpose?

In summary, I believe that the contribution of nurses is one of the vital pillars of health care not just because of the work they perform but also because the knowledge held by nursing professionals can make a vital contribution to reorienting the health model towards patients, service users and their families. Striving to find the best ways of caring for people, whether as a care nurse or as a manager, in addition to improving the quality of care, can be extremely helpful in resolving ethical dilemmas and problems because caring is above all a way of acting. An ethics which is based on principles and rights provides guidelines for behaviour; that is, it helps us to know what we should do. But an ethics of caring which gives us ways of acting helps us to know how we should do things. Together, these two types of ethics form the ethical basis of health care, and the active, independent participation of nurses in both is essential.

I will end by quoting something I wrote as a prologue to J. Riehl-Sisca's book "Modelos conceptuales de enfermería" *(Conceptual models of nursing)* published in 1992. "Any nurse who is concerned with the origin, development and application of models of nursing has the obligation to expand her knowledge of philosophy; by so doing, she can gain access to new knowledge, and identify and define the concepts, beliefs and assumptions upon which human life and education are built. These concepts are the reason why nurses exist, and provide the basis of their growth and development."

BY WAY OF A CONCLUSION

I do not intend this summary of the main ideas discussed during the seminar to in any way replace the need to read each of the individual contributions reproduced here, but rather to encourage people to read them. However, I do think it is worth focusing people's attention on some of the issues which came up during the seminar. The contributions of our two speakers and of various participants related the dilemmas, problems and ethical questions currently faced by nurses and those managing nursing services with the range of models or reference frameworks which exist in our health institutions. Despite the many legal, political and professional declarations arguing that care should be based on an integrated concept of health and on person-centred care, the majority of health institutions continue to be managed in accordance with a disease-based model of care and as a result they are organized around medical specializations. In this scenario, care is an undervalued activity which is very much left up to the individual providing it; it is not properly taken into account when resources are being allocated, and its results are not evaluated. At the same time, as a result of the major changes in nursing during recent years, nurses have become more aware of the ethical problems or dilemmas they face. Today, the professional paradigm which underpins both the ethical values and the actions of nursing is based on the notion of the person as an independent moral actor, on the idea of health as well-being, and on the concept of caring as a way of helping to support or enable people with actual or potential health needs. This means that the autonomy of the patient, his health needs and personal involvement, his privacy and confidentiality, the respect for differences, and cultural influences on health needs are all seen as essential aspects of the professional care provided by nurses, although services often focus on task-based working because they are organized around disease and curing. As a result, care remains focused on the disease and its symptoms rather than on the person and his health needs, and this is a major source of ethical conflicts.

Participants stressed the importance of the values of caring pervading the institutional philosophy and project, so that the nursing contribution is clear to those responsible for managing and organizing services. Another point to come out of the contributions was the notion that ethical commitment to the patient or service user and his family is not just an individual matter for each nurse, and for this reason nurse managers share with care nurses the responsibility of providing top quality care. The job of the nurse manager revolves around the need to support care nurses in their duty of caring, to cooperate in drawing up care standards, and to provide her with the necessary backup, professional

development and resources; in other words, to view intradisciplinary team working as an issue of shared responsibility towards the profession itself, towards the institution in which she works, towards patients, service users and families, and of course towards society as a whole, which needs to be able to see the benefit of providing professional nursing care as a means of helping people to have healthier lives. This means that caring must be visible, both at the level of direct care and as part of the philosophy, structure and organization of services and institutions, as a professional value but also and far more importantly as a social value. In short, what is needed is to be more aware of the inter-relationship between ethics and each and every one of the actions we perform. Ethical analysis cannot be separated from professional analysis, as ethics affects all of our professional actions. Clearly, professional analysis cannot be separated from the cultural context in which it occurs: care and culture go hand in hand. The management of care, understanding the word 'management' in the widest sense to cover both the nurse manager and the nurse who provides direct care, can be and in some institutions is a vital factor in improving health care. It has a specific contribution to make to the work of other health professionals because it is a source of knowledge about care as an act which is inherent in any human relationship, and this knowledge is necessary for the development of other disciplines such as medicine or social work. And it can contribute to society as a whole because it deals with human needs for the maintenance of life with regard to the processes of health and illness. This is the responsibility which nurses bear whatever setting we work in.

The seminar also gave rise to a number of issues for subsequent discussions. Listed below are the ones which strike me as being most interesting, although I am sure that every reader will have his or her own ideas:

- Nursing research which provides evidence for the results of caring.
- Team working between nurse managers and care nurses which strengthens professional autonomy with regard to care decisions.
- The responsibility for collaboration with other health professionals in order to improve health.
- Deepening our understanding of care as a human phenomenon which helps to convert interpersonal relationships into helping relationships.
- Continuous ethical training of professionals so that they can meet the demands of society and face the ethical dilemmas which arise when caring for people with health problems or people facing disability or death.

Montserrat Busquets Surribas

SEMINAR PARTICIPANTS

Speakers

- Mercedes Ferro, Director of the San Francisco Javier Psychogeriatric Centre in Pamplona.
- Núria Cuxart, Vice-president of the Official College of Nursing of Barcelona.

Chairperson

Montserrat Busquets, Lecturer at the School of Nursing at the University of Barcelona and member of the Board of Trustees of the Víctor Grífols i Lucas Foundation.

Invited specialists

1. Pilar Antón, Lecturer at the School of Nursing at the University of Barcelona.
2. Ramon Bayés, Professor of Basic Psychology at the Autonomous University of Barcelona.
3. Rosa María Blasco, Lecturer at the School of Nursing at the University of Barcelona.
4. Esther Busquets, Borja Institute of Bioethics.
5. Victoria Camps, President of the Víctor Grífols i Lucas Foundation.
6. Mariona Creus, President of the Official College of Nursing of Barcelona.
7. Margarita Esteve, Director of Nursing at Mataró Hospital.
8. Maria Gasull, Lecturer at the School of Nursing of Sant Pau Hospital in Barcelona.
9. Judith Gispert, Health and Hygiene Manager at the Albà Foundation in Barcelona.
10. Clara Gomis, Lecturer at the Faculty of Psychology and Educational Science of Ramon Llull University.
11. Luïsa González, Director of Nursing at the Hospital Clínic i Provincial in Barcelona
12. Núria Gorchs, Executive Secretary of the Centre for Ageing Studies of Catalonia.

13. María Francisca Jiménez, Lecturer at the School of Nursing of the Rovira i Virgili University.
14. Rosa María López Pisa, La Gavarra Outpatients' Clinic, Cornellà.
15. Cristina Martínez Bueno, President of the Catalan Association of Midwives.
16. Dolors Obiols, Lecturer at the Faculty of Political and Social Sciences of the Pompeu Fabra University.
17. Begoña Román, Faculty of Philosophy of Catalonia, Ramon Llull University.
18. Mercè Salvat, Secretary of the Catalan Nursing Association.
19. Jesús Sanz, President of the National Association of Nursing Managers.
20. Pilar Vilagrasa, Director of the Albà Foundation of Barcelona.

Publications

Monographs of the Foundation

13. *La información sanitaria y la participación activa de los usuarios. (Medical Information and Active Patient Participation).*
12. *The management of nursing care*
11. *Los fines de la medicina (Spanish translation of The goals of medicine)*
10. *Corresponsabilidad empresarial en el desarrollo sostenible (Corporate responsibility in sustainable development)*
9. *Ethics and sedation at the close of life*
8. *Uso racional de los medicamentos. Aspectos éticos (The rational use of medication: ethical aspects)*
7. *La gestión de los errores médicos (The management of medical errors)*
6. *Ética de la comunicación médica (Ethics of medical communication)*
5. *Problemas prácticos del consentimiento informado (Practical problems of informed consent)*
4. *Predictive medicine and discrimination*
3. *The pharmaceutical industry and medical progress*
2. *Ethical and scientific standards in research*
1. *Freedom and health*

Reports of the Foundation

4. *Las prestaciones privadas en las organizaciones sanitarias públicas (Private services in public health organizations)*
3. *Therapeutic cloning: ethical, legal and scientific perspectives*
2. *An ethical framework for cooperation between companies and research centers*
1. *Social perceptions of biotechnology*

More information in www.fundaciongrifols.org

FUNDACIÓ VÍCTOR GRÍFOLS I LUCAS
Jesús i Maria, 6
08022 Barcelona ESPAÑA
TEL. +34 935 710 410 FAX +34 935 710 535
fundacio.grifols@grifols.com
www.fundaciongrifols.org

06/3169
11106