

Modern Nursing in the Process of Ethical Changes in Surgery

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Abstract

The article discusses the ethical and social aspects of an elderly patient/client classified as a geriatric patient. It expresses the view on the surgical treatment from the field of the discipline of surgery, gerontology and nursing. The first author, a university professor of surgery, together with co-authors and a qualified nurse registered in the Czech Republic as well as in Great Britain, who works as a professional teacher of nursing, point to the required perspectives of health and functional status. They focus not only on the senior population in the Czech Republic in relation to a possible surgical intervention, but also on the sphere of its social problems. The article reflects the authors' work experience gained in hospitals in the United Kingdom. The comprehensive approach to the surgical patients is emphasised and the required perspectives of health and functional status, particularly at a higher age with respect to maintaining the quality of life, are highlighted.

Keywords: Surgery; Geriatrics; Ethics; Competence; Nursing process; Refugees

Introduction

There has been a significant increase of elderly people in doctor's offices and surgical departments and this trend is going to continue. In this context, we are talking about the "geriatisation" of medicine, in the process of population ageing and the onset of longevity. In the full extent, this current process also affects a large extent of surgery as the base field of medicine and irreplaceable discipline of nursing. These trends must correspond to a shift of clinical and departmental interests, transformation of out-dated approaches, structures of fields and services. It is about drawing the health problems and needs of the elderly from the periphery into the centre of attention (International Plan of Action on Ageing, Madrid, 2002).

Population ageing is a phenomenon, which is in all European Union countries seen as a natural evolution of civilisation bringing a number of problems, but also opportunities and challenges relating to, for example, the nature of long life in "old age", self-fulfilment and the possibility of exploiting the potential of the elderly. It also brings changes in the concept of employment and retirement, financing of health and social systems, as well as changes in stereotypes in providing support and services.

At this time, we must also deal with multiculturalism customers who migrate from their homeland to a country where envisage a happier life. This applies not only to themselves but also their children. The authors have personal experience with nursing care to migrants at a refugee camp in the Czech Republic and emphasize adherence to ethical principles in providing nursing and medical care. We have seen that many refugee clients in hospital and community settings and, because of language and cultural barriers, and have found it difficult to competently deal with the issues they face.

We can distinguish generally the three major sociocultural issues among refugees are culture shock, loss of status and role, and family disruption, all of which need attention from nurses. Restoring the mental health of refugees by addressing their sociocultural issues is a major responsibility and challenge for nurses. Refugees are among the world's most vulnerable populations. They suffer from various threats to their mental health throughout their migration and resettlement.

The hospitalisation of patients/clients with respect to demographic development and involution changes is being changed mainly on general surgical wards, as well as in specialised surgical clinics, and this trend is going to continue. It will be necessary to focus on surgical treatment at a higher age with respect to aspects such as maintaining, but also improving the quality of life. Attention also has to be paid to the availability of provided care, ethical and social equality of approach in order to ensure the satisfaction of elderly surgical patients. What is then the assumption of subsequent development?

Discussion

In recent years in the Czech Republic, the population of persons aged 90-and-older has reached about 27,000 and the number should reach 230,000 by 2050 [1,2]. The ratio of women to men is 4:1. In 2013, there were 2,857,856 seniors in the Czech Republic. However, the process of ageing population continued; in 2014, the average age of the population rose by 0.2 to 41.7 years, as well as the proportion of seniors aged 65 and over reaching 17.8 per cent [3]. A low number of deaths also led to an increase in life expectancy by about half a year from the previous 75.2 years for men and 81.1 years for women. The Czech Republic, following the example of Great Britain, deals with the quality of life of senior population, both in the treatment and in the area of nursing care.

According to UN prognosis, in 2050, about 2.2 million centenarians will live in economically developed countries; persons aged over 80

will make up 9.6% of the population. A shift in the centre of socio-demographic gravity from population ageing to longevity and from the consequences of general living to a life in advanced age is also being discussed. The authors are convinced that the demographic situation with regard to the clients - elderly surgical patients, will be developmentally the same also in other European Union countries.

We must reckon with the fact that in both, the field of surgery and nursing, new and modern surgical and nursing procedures will also increasingly affect elderly patients. In the last two decades, as well as today, we can see that surgery is continuously undergoing changes that were unimaginable a few years ago. Who would assume that abdominal surgery could be performed only by instruments introduced by the surgeon into the abdominal cavity through a small incision? And who would ever consider the possibility of a performance of real time remote surgical operations? More and more significant changes can be found at all levels of surgery, in a philosophy of surgery, surgery itself and as for the quality of life, this has been particularly emphasised. All this is reflected in the daily regime of patients in surgical wards, including new procedures and principles of nursing care.

From the modern perspective, perioperative care must ensure maintaining or even improving the quality of life of a patient, not only at the level of smooth operation, but also at the level of the patient's psychosomatic and social needs. This requires a daily close collaboration between the patient or the patient's family and a professional team of medical personnel - gerontologist, psychologists, physiotherapists and other professionals experienced in working with seniors and who are in close follow-up co-operation at one clinical workplace.

If an ill elderly person is egocentric, suspicious and fears that an operation might violently interrupt his/her life, the patient needs and requires respect, tact and patience. This approach applies mainly for acute illnesses and is highly contrary to the usual notion, i.e. the elderly suffering from an illness has no chance of long-term survival after a difficult medical intervention, especially after a treatment of malignant tumours.

Despite all the advances and new possibilities in the diagnosis, a large part of malignant tumours is indicated for surgery at an advanced stage, so it is not surprising that as far as elderly patients are concerned, palliative interventions prevail over radical interventions in many workplaces. In any case, the surgical procedure has to ensure a smooth postoperative course as well as the after-care with an emphasis on ensuring quality of life [4]. Even in the higher age group of patients the tactic and technique of surgery of a malignant tumour has to be subordinated to the main principle of cancer treatment, i.e. the curative nature of intervention. We are aware that the operating tactic and strategy is different for some tumours of the gastrointestinal tract, e.g., it differs in colon tumours and low-seated tumours such as rectal tumours where colostomy is often indicated as the only option.

This is also one of the reasons we decided to publish this article and a reason we strive to establish surgical-geriatric centres in all major hospitals. The ill elderly patient after a major surgery performed on the digestive tract often does not return exactly to the state he/she was before the disease and must adapt to new living conditions, especially in case of rectal cancer or generalised form of colon tumour where a permanent colostomy was performed [5].

After centuries the role of the doctor as well as the role of the patient, i.e., a person who expects or uses medical treatment or care,

was created. Today, the patient is also a client who receives the advice or services of qualified personnel. Medical care is not just passively accepted, on the contrary active cooperation is emphasised; it means that people feel responsible for their own health [6]. In the Czech Republic, the model of practical paternalism of doctors towards patients is still dominant, however due to the UK health standards, the situation is changing.

Nowadays, in the 21st century, the status of doctors and nurses as well as their mutual partnership in the care of a surgical patient is changing. Population ageing brings four priority challenge themes to health systems [7]:

1. Improving the health state of elderly people and young seniors; this also includes finding their place in the labour market, prevention and effective intervention of cardiovascular and cancer diseases and mental health disorders
2. Improving the functional health at an advanced age, i.e., 80 and over
3. Budgetary consolidations, the effectiveness of social and health spending in order to better respond to the needs of the ageing population
4. Health care for migrants to compensate for the loss of domestic labour

Comprehensive Geriatric Assessment (CGA) is defined as a multidimensional interdisciplinary diagnostic process that identifies medical, functional and psychosocial skills and limitations of frail geriatric patients/clients in order to develop an overall plan for their treatment and long-term monitoring in the field of surgery [1]. This is considered an intellectual and working core of the geriatric medicine.

L.Z. Rubenstein in 2006, the CGA's pioneer, claims that more accurate and comprehensive diagnosis is determined for the geriatric patients/clients of surgical departments due to CGA. Therefore, more adequate care with better outcomes is received, financial resources are saved and ineffective services are eliminated /cit. [8].

CGA is very important since the medical records nowadays are often in the form of long lists presenting types of diseases or nosological units but do not mention, comment or address more fundamental data, such as malnutrition, the nature of cognitive or actual disorders, physical disability, reason and extent of the use of support aids, the nature of falls, self-sufficiency rate, etc.

CGA can be especially performed, in reduced form, by paramedics of various specialisations, in the field of surgery and by surgical doctors alone, but the optimum is the establishment of multidisciplinary teams with a focus on geriatric surgical patients in collaboration with qualified surgical nurses in both the outpatient and hospital care. The doctor - nurse cooperation is very important in the surgical treatment. Their close work in cooperation with other members of the multidisciplinary team, such as a stoma nurse specialist, nurse treating pressure ulcers and their prevention, community nurse, nutritional specialist, social worker, psychotherapist or physiotherapist, is essential.

The comprehensive approach to a surgical patient is very important, especially at a high age with respect to maintaining the quality of life, which should be a priority both in the actual treatment and nursing care. This is reflected in the newly introduced concept called "Fast track perioperative care", i.e., a perioperative care leading to enhanced postoperative recovery. So far, we have had a personal experience with fast track surgery in some workplaces both in the UK and Czech

Republic. This modern approach was pioneered by Kehlet in 1995 and entails a multidisciplinary approach, including preoperative care with a clinical assessment of the client, perioperative high oxygenation, active prevention of hypothermia, epidural analgesia, the omission of preoperative colon preparation as well as the postoperative application of the nasogastric tube and drainage of the abdominal cavity. Antimicrobial prevention is systemic and short-term, and often only in single dose [5,9].

The authors also see unity in maintaining quality, accessible and equal health care for all, under the conditions of maintaining ethical and social standards. Within the complex evaluation of geriatric patients (CGA), not only the personality, physical health, functional performance and mental health are assessed, but also social context.

The item - social context - includes areas, such as social roles and relations toward social networks, functional efficiency and safety of the home environment where housing conditions, social needs, supplied or claimed services - day care, home care, personal assistance, emergency care, financial hardship, social benefits, an application submitted to a nursing home, determined dependency status, etc. are included [1,10].

Personal anamnesis of a geriatric patient/client is realised by a qualified nurse within the nursing process, for which the nurse is responsible. According to their education, the nurse can apply a modern nursing model focused on the individual patient care, who may lose self-sufficiency as a result of surgical treatment but also his/her social roles and social status [2].

All other qualified activities of the whole multidisciplinary team that cares for the client, including the attending surgeon, must be based on this fact. This transmission of information is very important in communication between the surgeon and surgical nurses for the final effect of surgical treatment.

Medicine of the 21st century is facing and will continue to face new professional, organisational and economic challenges, but also the challenge of the compliance with fundamental ethical principles of the medical and nursing professions. Principles, regardless of time varying relations between doctors, nurses and patients, can be derived from two basic rules, "Primum non nocere" – First, do no harm, and "Salus suprema lex aegroti" - The well-being of the patient is the most important law. The commercialisation of medicine and the current domination of economists in health care are increasingly distorting the ethical principles that should, in the interests of patients, be followed by doctors and nurses in the exercise of their profession. The independence of the doctor - surgeon in deciding the method of treatment is a basic and important condition that ensures patient safety [11,12].

Significant is the fact that the doctor - surgeon and surgical nurse are obliged to follow the basic rules of medical and nursing ethics [13,14]

These rules are:

1. Rule of independence - autonomy
2. Rule of doing no harm
3. Rule of heading towards the good, everything done by the doctor and nurse must be for the benefit of the patient/client
4. Rule of justice - each patient/client has the right to justice - in practical medicine it means that the patient must be given what he/she requires

Based on these rules, we must not forget what is important for the particular client, especially in acute surgery. Often not until hospitalisation the client learns what kind of a procedure (e.g., a permanent stoma, amputation) will be performed. It is worth mentioning here the newly applied modern medical philosophy according to which the patient is no longer told that he/she would be completely cured; instead help and life facilitation is emphasised in order to reach quality of his/her present life with illness [12].

In such serious situations, the role of the educated, empathetic care team, including the cooperation with the client's family or health and social aftercare institutions is irreplaceable. The doctor - surgeon must always proceed with "lege artis", i.e., strictly according to the rules of the medical profession.

Conclusion

For centuries the role of the doctor was established, just as the role of the patient/client. Doctor and patient are civically equal; they differ only in specialised education. The doctor - surgeon must always proceed with lege artis, which means strictly according to the rules of the medical profession. Medicine is becoming an economic sector with a large financial turnover, great economic and political influence, and the benefit of the patient can easily get into the background of interest. In addition to the development of medicine, its globalisation is also underway.

In everyday clinical practice, we have to state and remember that the doctor and qualified nurse have a general ethical and social obligation to observe their competencies and activities according to established standards, which they followed during their education. For the past 20 years, but especially after the Czech Republic joined the European Community, the actual clinical and nursing practice has recorded a noticeable development to the provision of high quality specialised care. The transition of professional nursing education to tertiary academic and non-university area led to the implementation of innovative methods in nursing practice along the lines of the British nursing standards which are focused on providing holistic patient care.

We managed to move from the obsolete functional system to a team nursing system, primary care and "case management"; we also managed to apply the method of nursing process. In Czech surgical wards, clinics and geriatric departments, planning the nursing care for the elderly surgical patients/clients is based on five basic requirements of nursing practice, which are as follows: competence (qualification for the nursing care), work commitment (dedication for nursing work), knowledge (expertise information from the field of nursing), empathy and conscience. Compliance with the Code of Ethics for Nurses contributes to the high standard of nursing practice of registered nurses.

Despite these requirements being mainly focused on health professionals who perform their professional activity in surgical wards and clinics, they are also applicable for other surgical disciplines. As already described in the discussion, modern medicine has changed its philosophy and it retrains from convincing the patient of his full recovery, instead help and life facilitation is emphasised in order to reach quality of the patient/client's present life with illness.

Conflict of Interests

The authors declare that no conflict of interest exists in relation to this article and that this article has not been published previously in any other magazine.

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