

Original Article

The Ethical Standpoints of Rehabilitation in the Nordic Countries- A Theoretical Study About Caring Sciences and Rehabilitation

Frilund, Marianne, RN, MnS, PhD

Associate Professor, Faculty of Medicine and Health Sciences, NTNU, Department of Health Sciences Aalesund, Larsgårdsvegen 2, 6009 Aalesund Norway

Vinje, Marianne

Physical therapist, Master of Management Advisor, Organizational Development Ålesund Municipality, Norway

Correspondence: Frilund, Marianne, RN, MnS, PhD, Ass. Professor, Faculty of Medicine and Health Sciences, NTNU, Department of Health Sciences Aalesund, Larsgårdsvegen 2, 6009 Aalesund Norway E-mail: mafr@ntnu.no

Abstract

Purpose: The study's purpose is to argue from a theoretical perspective, the importance of an ethical foundation or ontology in rehabilitation. The study aims to create a theoretical model where ethics and rehabilitation form a synthesis.

Method: The study is theoretical in the fields of rehabilitation and Caring Science. It follows a hermeneutic approach where the text is interpreted and analysed concerning context.

Findings: A common opinion, based on our material, is that rehabilitation is a relationship rather than a separate activity area. No professional group can invoke a monopoly on rehabilitation. Who formulates clinical practice goals and determines the patients' needs? How is the rehabilitation process tailored to the theme of "what is right" and "what is best for the patient"?

Conclusion: The theoretical model as it describes in this paper has opportunities to guide the ReHabilitating team against excellent ethical rehabilitation independent of clinical context.

Keywords: Rehabilitation, caring sciences, ethics, moral .

Introduction

Rehabilitation or Physical Medicine Rehabilitation has existed since the early 1900s. Physical Medicine Rehabilitation started in the US in 1921 by President Franklin Delano Roosevelt, to help himself and others affected with polio regain independence in daily life activities (Atanelov, Stiens, & Young, 2015). Many medical specialities focus on acute management and stabilisation of pathologic conditions, but rehabilitation focuses on holistic patient-centred care that addresses psychological and social circumstances. Physical Medicine Rehabilitation is also known as the "quality-of-life" medical speciality (Atanelov et al., 2015). Today, rehabilitation is organised as multidisciplinary teams that include physical therapy, occupational therapy, nursing, speech

and language pathology and other specialities. The team highlights their patients' rights and autonomy by maximising function and optimising their living situations to contribute to the community. (Atanelov et al., 2015; Maribo, Nielsen, & Jespersen, 2014) In the Nordic countries, the way of thinking in rehabilitation has turned over from malfunction and disease to human health resources. Rehabilitation emphasises interprofessional co-operation to meet the patients' needs and goals for a specific time. (Järvikoski & Karjalainen, 2014; Rundell et al., 2015)

In the field of rehabilitation, a variety of ethical and moral issues has emerged (Christensen, Mogensen, & Prastegaard, 2011; Fiskaa, 2015; Moe, 2017). Medical ethics provides a set of ethical principles that guide medicine's everyday

practice. Different healthcare providers have their guidelines for moral and ethics. (Hunter, 2013) Christensen et al. (2011), highlight four basic principles with relevance for professional caregivers and multi-professional teams. These principles are 1) autonomy 2) doing well, 3) not damage and 4) equal value of all people.

Questions asked in previous research were whether rehabilitation settings have standard ontologically rules for excellent and humanistic manners in the rehabilitation practice. (Chandratilake, 2014, Christensen et al., 2011) Chandratilake states that ethics and moral help us discover when we, as professionals in "the name of the good", are on the verge of overthrowing the clients' autonomy and integrity.

Researches show that ethical discussions and reflections make the professionals aware of what they see are desired and possible in rehabilitation. (Christensen et al., 2011; Frilund, 2013; Moe, 2017). The literature describes two different paradigms within the rehabilitation context. The first paradigm has a liberating perspective, highlighting the users' rights to participate in the rehabilitation process. The other paradigm emphasises economy, technological development, and efficiency. Such services are provided through standardised "clinical pathways", "patient pathways", standardised programs, "best practice" descriptions and other clinical guidelines. The two paradigms can conflict with each other, which result in ethical challenges and dilemmas. (Christensen et al., 2011, Frilund, 2013)

Being aware of the patient's potential or resources is an essential part of rehabilitation. In treatment, the individual is often perceived as an object to be treated. When care and rehabilitation professionals see the individual as a subject, they can take responsibility for his/her health promotion processes. The ontological basis for caring is to see patients as subjects or "gentlemen in their own lives". The multidisciplinary team has opportunities to create a trustful relationship and confidence with the patient. The patient's needs, wishes and expectations are linked to the group's intention, and the rehabilitation is carried out to care. Caring Science is universal science (Eriksson, 2009) and Froland and Alvsvåg (2018) emphasise that caring science as a discipline covers most health and social professions. Researches regard Caring as a fundamental condition of life, interpersonal

reality, and a moral imperative. When caregivers act ethically, human dependence, power, vulnerability, dignity, and courage are brought to life. (Eriksson, 2007, 2009; Eriksson & Lindström, 2009; Førlund & Alvsvåg, 2018) An ethically aware caregiver strives to "do good", "do right" and "take responsibility" (Frilund, 2013, 2018). The WHO conference in 2017 showed a need for increased awareness and support for the rehabilitation field. The action program presented has been central to the political discussion in the Nordic countries. (WHO, 2017)

The purpose of the study

The study's purpose is to argue from a theoretical perspective, the importance of an ethical foundation or ontology in rehabilitation. The study aims to create a theoretical model where ethics and rehabilitation form a synthesis.

The study aims to provide answers to the following issues:

- a) What is the main idea of rehabilitation in the Nordic countries?
- b) Which ethical and moral principles govern Nordic countries' rehabilitation activities?
- c) Synthesis: A theoretical model describing the synthesis between caring ethics and rehabilitation

Methods: The study is theoretical in the fields of rehabilitation and Caring Science. It follows a hermeneutic approach where the text is interpreted and analysed. (Howell, 2013) The study is described from an organisational perspective based on Nordic countries' national documents such as legislation and recommendations and relevant previous research.

Data material and analyse: We have obtained the data through manual search and a "snowball strategy". By using keywords like "rehabilitation", phrases like "what is rehabilitation", "definitions of rehabilitation", we found public reports, recommendations, and legislation with relevance for rehabilitation area. The first step in the data collection started by studying the various countries' official websites: Ministry of Social Affairs and Health (<https://stm.fi/sv/framsida>) and The Finnish Institute for Health Welfare. (<https://thl.fi>). THL is a Finnish expert agency that provides reliable information on health and welfare for decision-making and activities in the field. (<https://thl.fi>). The Norwegian Directorate of Health, whose

propose is to improve health service quality and promote factors that bring good health to the population. (<https://www.helsedirektoratet.no/>). The National Board of Health Denmark (<https://www.sst.dk/>) and National Board of Health and Welfare in Sweden. (<https://www.socialsryrelsen.se>) has a wide range of activities and many different duties within social services, health and medical services, patient safety and epidemiology.

The materials are subjective choices by the authors, but we judge the material as the representative for our research questions. We used a form of thematical analyses to analyse the data. (Braun & Clarke, 2006) The analyse process gave answers to questions one and two, which provided input for model development. The Consensus of the study "the theoretical model of synthesis between ethic and rehabilitation" results from logical argumentation, inspired by the theoretical model developed by Frilund (2013, 2018), adapted to the rehabilitation context. The result is seen as probable and credible based on the selected premises on which the study is based.

Preunderstanding and ethical principles: The article's authors represent two different professions: physical therapy and health sciences (nursing - caring sciences). We hypothesised that rehabilitation in the Nordic countries have a robust ethical standpoint, but it is not unambiguous, or explicit. We also hypothesised that a direct value basis in rehabilitation, both at the individual and organisational level, is a prerequisite for the patient/user to have real possibilities to ethically proper rehabilitation. A rehabilitation that initiated health processes relieves suffering towards life meaning and quality of life despite illness and disability.

Results

What is the main idea of rehabilitation in the Nordic countries? Rehabilitation is seen as part of its welfare services. (<https://www.norden.org/sv/info-norden/rehabilitering>) Moreover, it is defined as both an individual and community-oriented activities based on the client's clear goals. The rehabilitation goals are to promote the individual's functional ability, well-being, and employment rate. The rehabilitation activities intend to support the rehabilitation patient and safeguard his / her resources, promote an independent life, work capacity and social

integration. (<https://www.norden.org/sv/info-norden/rehabilitering>; Fiskaa, 2015; 2009; Järvikoski & Karjalainen, 2014; Vik, 2018). Rehabilitation is characterised by coordinated, coherent and knowledge-based activities. (<https://helsedirektoratet.no>, 2020; The Norwegian Directorate of Health, STM, SST, and National Board of Health and Welfare)

Rehabilitation aims to promote patients or users opportunities to achieve the best possible functional and coping skills, independence, participation in education and working life, and managing society and socially. (Meld. St. Nr. 47, Norwegian health care coordination reform, 2009, NOU 2011:11Innovasjon i omsorg, 2011; The Norwegian Directorate of Health, 2012). All the Nordic Countries highlight rehabilitation as a community-oriented activity focusing on promoting the population's functional ability and social survival from a holistic view on the human being, independent of physical, mental cognitive or social limitations.

"User participation" is a statutory right. User participation can contribute to increased accuracy in the design and implementation of both general and individual offers of rehabilitation services. (<https://helsedirektoratet.no/folkehelse/psykisk-helse-og-rus/brukermedvirkning>). User participation has an intrinsic value, including the person seeking help wants to control one's own life and receive help on their term (Moe, 2017; Pettersson & Iwarsson, 2015; Ojdgard, 2018). The same is described in Finland and Sweden as patient-centred versus client-centred care and highlights values as autonomy, integrity, and respect.

Conclusion: However, the user's role as the expert of their lives is not apparent (Solbjør, Ljunggren and Kleiven, 2017). It is not clear, who formulates clinical practice goals and determines the patients' needs.

How is the rehabilitation process tailored to the theme of "what is right "and "what is best for the patient"? A common opinion, based on our material, is that rehabilitation is a relationship rather than a separate activity area. No professional group can invoke a monopoly on rehabilitation.

Which ethical and moral principles govern the rehabilitation activities in the Nordic countries. Ethics refers to considerations, what is "right or good to do", and what norms and

rules should be followed. Common ethical values and rules highlight the level of “the good” rehabilitation practices. Moe (2017) highlights a conflict of interest between the desire to offer citizens better services and create a better economy in the municipalities. This conflict of interest is visible in the tensions between professions, norms, values and instrumental innovation. That was reflected in research as communication problems, barriers, counter-voices and instability. (Moe, 2017) The conflict of interests has led the foundation for further reflection, Moe (2017) state. Frilund (2013, 2018) found a clear discrepancy between ethical ideals and realistic possibilities to act morally within elderly care. The discrepancy between willingness and perceived realistic possibilities increases the risk of negative effects on work quality. Still, the discrepancy also shows the risk of emotional burnout among care professionals. When ethical ideals are put concerning moral practices, ethical dilemmas and feeds are revealed. (Frilund, 2013; Fiskaa, 2015; Moe, 2017). The view of the user as an active participant in the rehabilitation process can contribute to positive effects of rehabilitation, which can reinforce the helplessness that many patients/users experience.

Two paradigms have been discussed earlier in the paper. One paradigm takes for granted an increased focus on the individual's treatment and co-determination in their treatment. The second paradigm takes for granted a development that emphasises economy, productivity and efficiency, with a standardised range of services. In Norway, we can see the effects of paradigm two in all recent developed packages and programs. (Moe, 2017) These two paradigms have two different ontological standpoints, which quickly comes into conflict with each other. When Political intentions and staff' intentions come into conflict, the gap between Caring ethics and financial values is beginning to create a divergence in rehabilitation practices. (Moe, 2017).

Our mind includes our attitudes and culture and may need changes emphasising coping in everyday life and close cross-professional and cross-governmental collaboration. What ethical value or ontology would be ideal in rehabilitation practice to reach the rehabilitation intentions? Conclusion: The rehabilitation practice goal is unambiguous, but the path, way of thinking and attitudes are far from the individual team

member's values and basic attitude. (Christensen, Mogensen, & Prastegaard, 2011; Frilund, 2013; Moe, 2017). Ethics is more about wisdom and judgment than about calculations and unquestionable answers. (Fiskaa, 2015). Fiskaas study shows that knowledge of ethical theory can help clarify the dilemmas, and further create reflection beyond the purely personal level. Is it relevant to highlight caring sciences as a reference for ethical discussion and rehabilitation reflection? The physiotherapists in Fiskars study call for more knowledge and guidance in ethical discussions and ethical reflections. It is not only physiotherapists who experience ethical dilemmas in their daily work. It is a common problem among all caregivers (Frilund, 2018).

A "synthesis between ethics and morality in the rehabilitation field" takes shape. The study's main intention was to argue for a synthesis between caring ethics and the field of rehabilitation. The model outlined in Figure 1 can be described from four cornerstones: 1) The ethical values and ontology of rehabilitation, 2) Person-centred approach in rehabilitation 3) Morally defensible rehabilitation practice and 4) Ethical leadership and coordination.

The first cornerstone, "The ethical values and ontology of rehabilitation", can be described with entities such as ethical ideals, dignity, autonomy, integrity security and community (Frilund, 2018; Fiskaa, 2015; Moe, 2017) Ethical ideals from our actions and decisions. Ethical ideas are implicitly found in the documents about rehabilitation. The patient's position and the client in Norway, Sweden and Finland are based on dignity, autonomy, security (Act on Patient and User Rights LOV-1999-07-02-63, Act on the patient's position and rights 17.8.1992 / 785, the Patient Act, 2014: 821). Our ethos and ontology reflect our ethically manners. The relationship between ontology (ideal) and moral practice (ethical possibilities) need not necessarily be linear. However, moral acts are influenced by the reality in which the activity is exercised and those who practice rehabilitation. The rehabilitation patient's needs, goals and expectations have to be met, but the level of needs satisfaction are dependent on the limitations or resources allocated to the rehabilitation area. (Christensen et al., 2011; Frilund, 2013; Moe, 2017; Hjortbak et al., 2011). When ethical ideals and patients "needs" are not met, ethical dilemmas and challenges arise, reflecting ethos of the rehabilitation team.

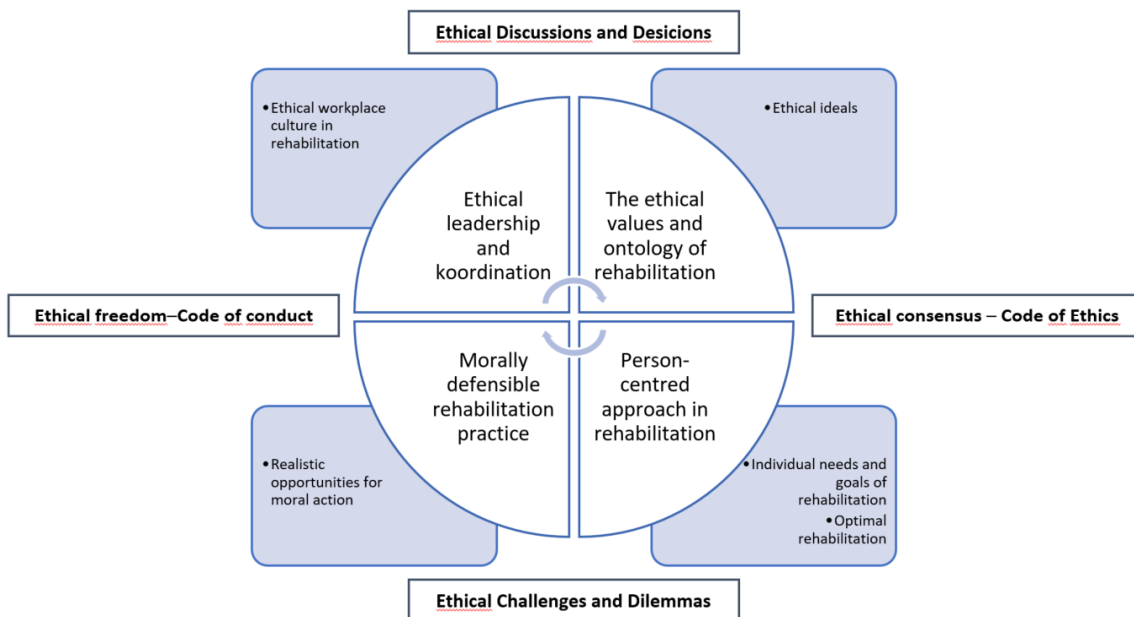


Figure 1 Synthesis between ethical ideals and rehabilitation modified by the authors (The model was initially developed by Frilund in 2013 and modified by Frilund in 2018).

Moral manners in practice reflect the professional worker's ontological values, which is far influenced by the professional ethics the person represents. To achieve “qualitative ethical rehabilitation”, the team should reach a consensus about ethical values and ethical manners acceptable for the team. We must ask, how the patient's autonomy, integrity and dignity are preserved in the rehabilitation process (Gutenbrunner & Nugraha, 2018; Rundell et al., 2015; Angel et al., 2011; Fiskaa, 2015; Frilund, 2013; Moe, 2017)

Ethical leadership and coordination are the fourth cornerstone. One of the essential tasks for leaders is developing an organisational culture. A rehabilitation that safeguards the user's autonomy, security, dignity participation is not a matter of course, even though it is stated in documents and legislation. A leader with courage, visions, ethical spirit has a crucial role in the content of ethical discussions and the decision-making process. (Frilund, 2015)

Summary and Discussion: In Finland, a working group was appointed in 2016 to map out

the rehabilitation activities, based on a comprehensive survey of various actors involved in rehabilitation in Finland. (STM, 2017). In Denmark, the starting point was the rehabilitation patients' experiences of rehabilitation, the users' stories. (Marselisborg-Center, 2004; Feiring & Solvang, 2013) In Norway, the Ministry of Health and Care Services highlighted a psychosocial model for rehabilitation, emphasising interdisciplinary efforts and co-operation (Meld. St. No. 21 1998-99). Meld. St. No. 21 outlines a sustainable model for the welfare society based on prevention, early intervention, rehabilitation and coping. These should improve the individual's ability to function and reduce the need for costly treatment in the specialist health service (The coordination reform of Norwegian health care, 2012, Meld. St. No. 14; Meld. St No. 26)

However, research shows the needs for analyse-, discuss-, develop-, and implement ethical theories to guide functional rehabilitation. Research highlights a focus on opportunities and not limitations. (Chandratilake, 2014;

Christensen et al., 2011; Fiskaa, 2015; Maribo et al., 2014). A shared understanding between members in rehabilitation teams are a prerequisite for interdisciplinary collaboration in a workplace (Chandratilake, 2014; Christensen et al., 2014)

The essential idea in rehabilitation from an organisational perspective is to provide rehabilitation as a part of the welfare service and focus on the patients' individual goals, needs, and wishes. Teams are made up of different professions with different ethical and moral principles. Moral and ethical principles appear indirectly in the analysed documents but there are still needs for a specification of what ethics and morality mean for the rehabilitation team. How does the interdisciplinary team understand the concepts of "user participation", "patient-centred" and "autonomy", do they understand the concepts at the same way?

Caring is a common denominator for all healthcare professionals regardless of profession, based on "caritative" ethics. Caring stands for human dignity, autonomy, and respect. Caring Science has opportunities to be the theoretical framework in rehabilitation. (Fiskaa, 2015). Quality and the optimal rehabilitation level are affected by whether needs and available resources are in balance with each other. In rehabilitation, reliable instruments are needed to determine the patients' rehabilitation quality. (Gutenbrunner & Nugraha, 2018; Moe, 2017; Najem et al., 2018; WHO., 2017) A discussion about optimal resource allocation becomes an essential discussion in rehabilitation. Good quality of service is understood even though perspectives and definitions of "good enough". The rehabilitation teams have to define the excellent quality of rehabilitation from an individual perspective. Do we meet our patients' needs, desires and expectations by the services we offer? In light of the third cornerstone (Figure 1), we can determine how our ethical consciousness expresses itself. Can we reach a consensus decision within the team, or are we satisfied that team members define their own quality and ethical manners? The theoretical model (Figure 1) is a model we can use in praxis to develop and quarantine excellent rehabilitation to patients.

Our conclusions are that the theoretical model as described in this paper has opportunities to guide the Rehabilitation team against excellent ethical

rehabilitation independent on clinical context and profession.

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