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Coaxing as a Strategy to Deal with Ethical Issues in Community Home Care: An Ethnographic Study

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ABSTRACT

Introduction: The provision of home health care services increases as a desirable option in western society. Previous studies indicate that health care professionals encounter ethically difficult situations when providing home care services. There is a lack of studies describing ethically difficult situations through observation. This study aimed to explore ethical issues experienced by healthcare staff when providing community home care services.

Methods: Qualitative design, using the ethnographical approach. Data gathered as fieldwork in terms of memos, non-participant observation and informal interview with registered nurses (*n*=8), and nurse-assistants (*n*=4) during three weeks (in total 148 hours, 7am -5pm) **.**

Results: The result generated two main categories: 1) *To balance stakeholders' requirements*, and, 2) *Strategy to deal with ethical issues*. Coxing was used as a strategy to deal with ethically difficult situations in patient care. The results showed that the complexity of the ethical issues is often related to personal values and organisational impact. The staff experienced need for a structured approach to assist them in identifying, analysing, and resolving ethical issues that arise in clinical practice. Health care organisations, personnel and patients are disagreed about values and choices that could lead to the best course of actions**.**

Conclusion: This study reveals that the ethically difficult situations in the context of community home care services are complex and are influencing the provision of care. The personnel enforced to find a balance between different expectations and from different stakeholders. To deal with these situations coaxing was used as a strategy for managing ethical issues.

Keywords: Homecare nursing, Healthcare professional, Ethics

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Introduction

In recent decades there has been a significant rise in the numbers of older people who live alone (1, 2, 3) and receive community care services. The general opinion in western society seems to give each individual the right to live in their own homes as long as possible (2,4). Community home care services organized that care is administered at home by certified personnel, such as visiting registered nurse (RN) or nurse assistants (NA) (5,6). The service they provide consists: a) post-acute recovery rehabilitation, b) maintenance of functionality for older people, c) palliative care services (7,8), or psychiatric patients who need daily check-ups, medications, and basic nursing care.

Health care professionals who work in community home care face many demands and the ethically difficult situation daily (9–11). These demands could be from the law (6,12), the next-of-kin (13), and the patient to deliver care in a certain way. Difficult situations occur when health personnel encounters situations that they uncertain which values and whose values should or could be applied (14–17). The consequences of feeling uncertain or insecure which care to provide could cause a sense of feeling powerlessness (18). That could lead to moral distress, as a consequence of feeling insufficient and inability on how to provide the best course of action. Factors such as institutional constraints (19,20), inadequate resources in form of a shortage of personnel, lack of respect from patients and bosses (21), consent for treatment (22), powerlessness overwork situation (23) could have an impact of the health personnel's feelings. Ethically difficult situations are described in the context of hospitals (18,24–29) as well as in nursing homes when providing care for older (14,30–32). These situations are examined among healthcare personnel using face-to-face interviews (30), focus groups (25), questionnaires (27,33), and telephone surveys (34).

However, to our knowledge, there is a lack of studies describing ethical issues through observation during the provision of community care services. This study aimed to describe ethical issues experienced by healthcare professionals and the strategy used to deal with these issues.

Methods

Participants

The study has a qualitative descriptive design, using an ethnographical approach (35).

This study was a part of an ongoing collaboration between municipality healthcare service and a university college in Norway. The initiatives were taken by the municipality to develop the community care service. Their basic values were to promote and facilitate meaningful days for the residents in the community who receive home care.

A manager from the community service unit supported this research by acting as a *'gatekeeper'* and informed staff about the approach of this study. The inclusion criteria for this study were healthcare personnel with some type of qualification. We included only registered nurses, managers, nurse assistants between the age of 20-65 despite years of work experience, education, or employee contract. We excluded all the healthcare personnel who did not have any degree or permanent contract, or those who were retired but worked a few hours a week. The certified staff (n =26), registered nurses *n*=10, and nurse assistants *n*=16, in this unit, were invited to a staff meeting to get information about the study. The characteristics of the healthcare personnel are described in table1.

In total, eight nurses and four nurse-assistants showed interest and were included in the study. The participants were male and female, aged between 20 and 58 years (mean = 41), and had experiences from health care work between one to 20 years (mdn =10).

Data Collection Methods

The data were conducted as repeated non-participating observations, written memos, and conversations with the staff. The data were gathered between April to May 2016. The observation time varied, during the day shift between e.g. 8:00 a.m.

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to 4:00 p.m., other times were during the evening, e.g. 4:00 to 10:00 pm. Each observation depleted from 5 hours to 8 hours including time for transcription. The fieldwork in terms of observations were repeated and counted from 1-6 at each patient's home. In total (*n*=122) observations of home care services were accomplished in (*n*=22) different patient home.

The field notes were written down immediately after each observation. The data was a description of the setting, the staff who provided care, caring time e.g. how long each personnel stayed at patient's home, the place where the caring took place (e.g. in the kitchen, bedroom, living room), what type of care were provided, the staff-patient interactions and brief information about the action. The notes and observations were transcribed immediately after each observed situation (36). The questions that were related to the situations asked were:

1) Describe the situation you experienced?
2) How did you experience this situation?
3) What did you experience as ethically difficult in that situation?
4) Could you tell me more specifically about your feelings concerned about that?
5) How do you usually solve situations like this? Do you use any kind of ethics support?

The collected data were used for two different publications. The first article focused on ethical issues on a systemic and organizational level, while the current article is focusing on the strategies to deal with ethical issues.

All data were transcribed and organized as a whole into the software Nvivo10 (37). The analysis process was inductive and close to the original text. The data were read and reread to gain a general impression of the content (38,39). The author constantly took a step back to reflect on the data critically and tried to be aware of the pre-understanding that could matter when analyzing the data. Questions were asked to the text about what happened during the observation ('*etic view'*) and which kind of ethical situations the personnel expressed they were experienced (*'emic view'*) (40).

The analysis process was conducted in several steps. First, highlighting the text containing meaning units. Second, the meaning units were coded. Third, the codes were reviewed and compared with each other and grouped based on similarities and differences with considerations of relevance to the research aim. Fourth, the codes were grouped to merge into subcategories and categories. This step was critically discussed in a research group to abstract them and subsequently find the best appropriate description and a possible understanding of the material. Two categories emerged: '*To balance stakeholders' requirements'* and *'Strategy to deal with ethical issues'*.

Ethical considerations

Approval for the study was obtained from the Norwegian Social Science Data Services (NSD) and the Regional Research Ethics Committee (ID-47995). Both oral and written information about the study was provided to all the staff and the patients in advance. The information letter clarified that their participation in the study was based on free will, that they could interrupt their participation whenever they want. All the staff (*n*=12) and patients (*n*=22) gave their consent to be part of this study. The quotes that were used in the result section are slightly modified (replacing he/she or vice versa) to prevent the risk of being recognized. The collected data for the project was used for two different articles.

Results

The results are shown in terms of two categories: 1) *To balance stakeholders' requirements;* 2) *Strategy to deal with ethical issues.* (Figure 1.)

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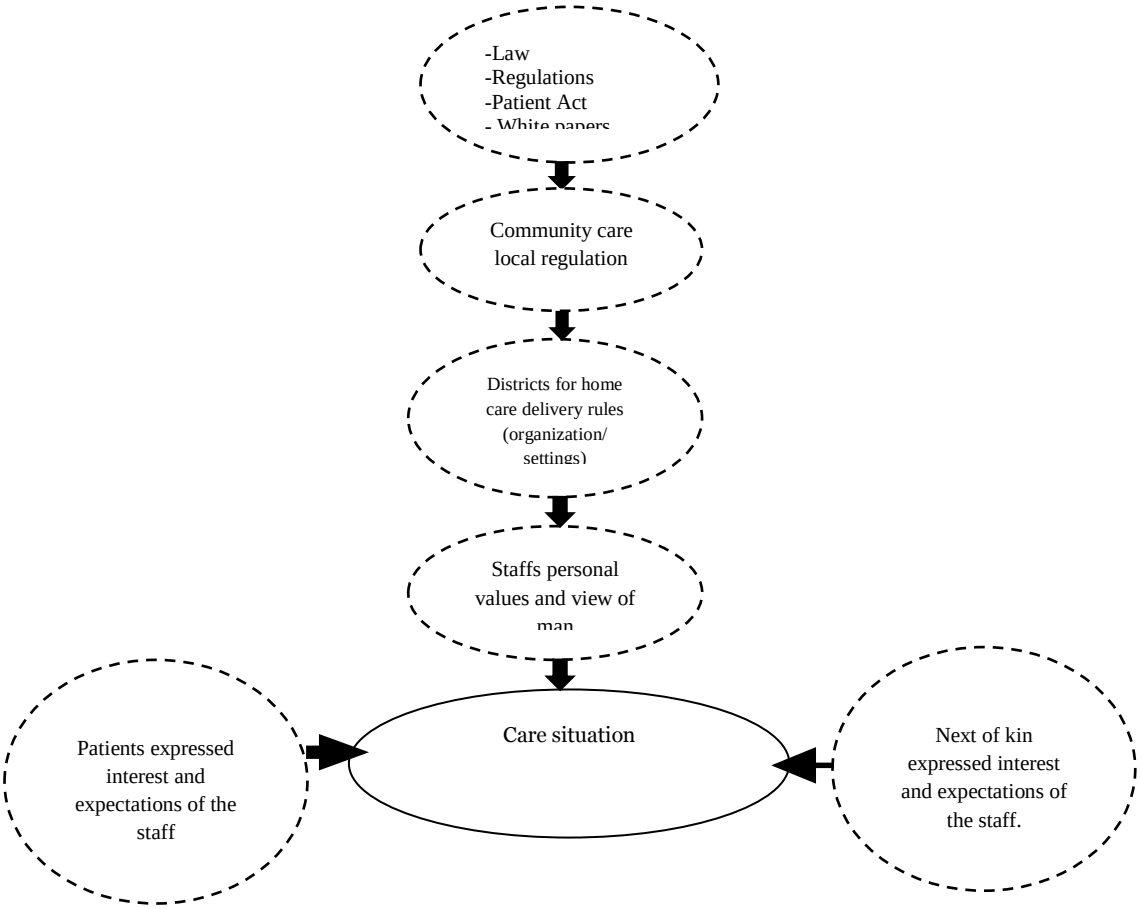

Figure 1. Factors and triggers that have an impact on care.

Table 1. Characteristics of the healthcare personnel

Profession	*N*	*%*
Certified Staff	26	
* Rn	10	
* NA	14	
* HA	2	
Participatnts		
Male		23%
Female		77%
Age		
Mean	41	
SD	16,8	
Other educations beside the healthcare profession		
Teacher	1	
Community service	3	
Health administrator	2	
Politician	2	
Clinical health supervisor	6	
Physiotherapy traineer	2	
Previous work experience in healthcare in general (in years).	15	
Previous work experience of clinical ethics support among staff		19%

* Registered nurse, Nurse Assistants, Health administrator

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To balance stakeholders' requirements

The ethical issues appeared to be multifaceted and complex. This category describes the complexity of situations that raised during the care situation. These situations were experienced by the staff to be on different levels: On a system level, the law combined with the ideology and expectations of person-centered care were important factors that sometimes could be felt as demanding. The staff experienced that they were obligated by the law to deliver care that is secure, good, and equal from that point of view but also individualized. The care should be given with consideration of the patient's self-determination and choice of care. This was sometimes conflicting with secure and equal care.

On the organizational level the districts of home care delivery, which is the health care unit, have the responsibility to deliver the services that are required. The result showed that the staff described their everyday work follow a certain direction when planning the care for different patients in a similar manner. They needed to consider the patients' voices and interests in different caring situations. They intended to involve the patients and respect their integrity and autonomy. Also, the staff experienced that they need to take into consideration the interest of the next-of-kin. Furthermore, the staff, who deliver the care, their value and view of the man on the best course of action toward a patient, or how to act in the patient's home influence kind of care they intended to provide.

These demands seemed to be stressors that triggered the staff in mutual directions. These stressors could be for example that the staff experienced the pressure from their organization by having responsibility for the care delivered during a given period and for high numbers of patients in one hand. Some of the patients needed more care, time, and attention from the staff on another hand. These internal and external factors that influence the provision of care (Figure 1.) are not constant but are varying more and less depending on the situation to another among the personnel as well as from patients to another. This multi pressure seemed to create a sense of uncertainty among the personnel.

Staff members personal values

The staff seemed to be affected by their values or the values of their colleagues upon the best course of action. Time and effectiveness seemed to be prioritized before the patient's needs, their voice, and involvements in caring situations. Instead, it seemed that the staff decided what was in the best course of action for every patient. They seemed to provide minor care and spend less time with certain patients. Especially, patients with psychiatric disorders, who got less attention and care. The results show that the staff often prioritize somatic patients before the psychiatric one. The staff had different attitudes and behavior when entering the patient's homes an observation showed. In some homes, they tend to take off their shoes while in other homes they continued to wear them, which was particularly observed when visiting psychiatric patients, and older patients who lack next-of-kin. Another observation revealed that the staff delayed responding to psychiatric patients who were in pain. They thought the patient's pain was not legitimate to respond, and this statement was partly based on what the colleagues have said during an informal meeting in the staff-room. It seemed also that the staff sometimes went against the physician's recommendation:

" I think it is an ethical problem [….] the doctor said we should treat them equally and exactly in the same way, but we don't. Because we from the experience learned that the patients are different. I don't think it is right to do so as we do [….]" (all data)

Besides, the observations showed that the staff sometimes treated the patient as a child when they were not able to take care of themselves. Staff expressed that they were 'taking over patients' life more or less to give them care'. It seemed that the staff tried to create good days for the patient and recreate a good relationship and trust to help the patient reduce the drugs.

Patients' expectations

Another ethical issue concerned how to maintain

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or restore a good relationship toward a certain kind of patient who had difficulties to reduce a drug-related medication. The result showed that there was a situation where the staff experienced that the patient was not collaborating with them upon the best course of action. This could lead to a certain kind of frustration and ethical issue for the staff. The consequences could be that the care could not be provided following the patient's interest. According to the staff situations like this started when they trusted the patient in the beginning and had some kind of agreement on how to downsize drug-related medication.

But unfortunately, the patient failed to stay to the contract they agreed upon off, and that perceived as irresponsible by the staff. They felt that they were responsible and contributed actually to make a person be addicted to strong drug-related medication by increasing the dosages than reducing. According to the personnel, they had tried many times without any further success. The patients expressed on the other side that they are in pain and needed more medications.

"It is very difficult because of us… feel somehow that we are contributing to making some people high on drugs all the time. It is a lot of medication this patient get" (Informant 12)

The next-of-kin expectation

The staff experienced that the family members could lead to ethical issues when they demanded more medication to their adult children in case of pain management. The staff experienced frustration over the involvement of next-of-kin, and their demands were felt inconvenient. The nurses described that they are trying to do their best for the patient to make them feel better and being relieved from pain, but next-of-kin members hindered them to do their job. The staff experienced frustration over this kind of situation, and as some of the consequences, they started to talk badly in the staff-room about the patient and their next-of-kin e.g. labeling them being like a *'child'* or '*demanding*'.

Another aspect of ethical issues concerned older patients with eating difficulties. The staff described situations where they were required by the family to feed the patient, even though the patient didn't want to eat.

" [….] You could get into trouble if you do not make sure that the patient is eating. It happens that they talk hard to you, for example, the family members tell us "you are not doing your job". So that is problematic sometimes." (Informant 10)

Other ethical issues concerned information about patient's health conditions. The family members seemed to require information about the process of caring and treatment on a daily basis. The staff experienced that as problematic, especially when the patient disagreed. This could create a dilemma for the personnel. On one hand, there could be a conflict between the staff and the next-of-kin when the staff respected the patient's choice of not allowing the information to be given to the next-of-kin. On the other hand, the personnel could conflict with the patient and law when disclosing information about the health condition. That would also mean to default the principle of confidentiality.

"…. They want us to inform about everything we do for the patient…the sons require information about their loved one, and sometimes the patient doesn't want us to give them the information. The patient does not give their consent and we try to inform the next-of-kin about that, but they have difficulty accepting that. It can raise a conflict." (Informant 11)

Strategy to deal with ethical issues

Coxing

The Staff seemed to have developed *'coaxing'* as a strategy to deal with ethically difficult situations. It seemed that the staff many times were maneuvering the conversation with the patients to a certain course, especially when the patients say no for food or have a shower. Also, they try to get the patient to be involved by having a kind-hearted attitude mixed with coaxing. This approach seemed to make the patient's feeling to be involved by getting the impression that the suggested choice is theirs than the staff members. The staff described the coaxing phenomena as an effective

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strategy and a way to deal with ethical issues:

" So the question is if it is ok to coax the patient? Sometimes if you let them think about what they want and how they want. There is a risk that you never get an answer." (All data)

The strategy of coaxing the patient seemed to be efficient and work, especially with elderly patients. But at the same time, they described that they must be careful and respect the patient if the patients did not have an appetite (e.g. in feeding situations) at the moment, but at the same time, they experienced difficulty understanding why the patient didn't want to eat. The observation showed that coaxing was used for several minutes to persuade the patient to eat before the food was placed on a table.

The staff was not able to wait for a long time, instead, they coaxed the patient to get them up from the bed, get them to the shower or wash them, or preparing food for them. The reason for coxing according to the staff was that they had other patients waiting on the list to take care of. Coaxing seemed to be the solution for them to move on in their job and deal with an ethically difficult situation without insulting the patient's autonomy.

Discussion

This study aimed to describe ethical issues experienced by healthcare staff and how they were dealing with them, observed during the provision of community care service. The result shows that despite the ethically difficult care situations connected to elementary care, they appeared as complex care situations due to several internal and external factors. However, these factors influence the provision of care are not continual but are varying more and less depending on the situation to another among the staff as well as the patients. However, there was a relationship between the work of experience and handling the ethically difficult situation (*n*=15/26). More work experience could generate more skills and knowledge in managing the situation. There were no differences between genders in managing the ethically different situation. There was also a relationship regarding other education than the profession. Those who had more education than one were more likely to solve the ethical issues better than those who had not (*n*=16/26).

The staff was struggling with finding a balance regarding different expectations and needs on system-, organisation-, and personal levels that were influencing the provision of care. These overloaded pressures seemed to create a sense of uncertainty among the personnel. To deal with these situations coaxing was suggested and used as a strategy for performing the care as they were expected to do. In addition, they mirrored their frustration over the inability concerning these caring situations with each other. Disappointment over the situation could generate feelings as being frustrated over the situation (18). The consequences of this frustrations could be that the personnel started to talk badly in staff-room about the patient e.g. labelling the patient as being like a 'child' or 'demanding'. According to Jeffery (41) and Dingwall (42), the personnel sometimes label the patient as being 'bad', 'difficult' or 'children' that is when talk negatively about them. These kinds of attitudes or situation place the concept of person-cantered care at the stake. In order to provide person-centered care, it is crucial to have a mutual relationship building on respect where the staff is aware of patients' values and desires. A relationship in community care should differ in comparison to institutional care. In the home care service, the relationship is often a long term which can allow the staff to develop a flourishing relationship (43). This could be an ideal of care, but on the other hand, the result showed that the personnel felt a lack of time and pressure to deliver effective care and to be able to help at many patients as possible during their workday. Lack of time and prerequisites may have influenced and limited the options of building relationships based upon the person-centered care values. An important aspect occurred when a person was treated as a 'diagnose' more than as a person with values and self-determinations. This view of man was observed in a personnel meeting with patients with psychiatric disorders.

The interest and expectations from the next-of-

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kin when this was not following the patient's wishes showed to be other challenges that were expressed by staff. To perform care following the wish of the next-of-kin have been described in several previous studies, that the next-of-kin could have power on the caring process, an unrealistic expectation on the personnel (33,44). Finally, even though the staff used coaxing as a strategy to achieve their goal with care, they were uncertain if the coaxing was the best course of action. The study indicated that the ethical reflections could enhance the awareness of personnel's everyday work related to the complex situation and develop tools on how to deal with it in the context of community home care.

Strengths and limitations

The strengths of the present study are repeated observations followed by the staff's experiences related to ethically difficult situations that gave rich data. The combinations of these data collection provide knowledge about the action and reflections. The knowledge from this study complements previous studies concerning the ethically difficult situations in-home health care services. A possible methodological limitation might be that the staff in this study acted in their best way in front of the researcher but since the observations were performed with different staff and repeatedly may this limitation have been reduced. The author was aware of his role and pre-understanding by discussing the collected data with the staff in the field and other researchers. Having a pre-understanding and being a part of the field can unavoidably impact the result, but at the same time, pre-understanding could help the researcher to see a new aspect of reality (45).

Conclusion and implication

This study reveals that ethical issues in the context of community home care are complex where the staff enforced to find a balance regarding expectations and needs on different levels. Staff experienced that demanding expectations are negatively influencing the provision of care. To deal with these ethical issues the staff developed a coaxing strategy.

The study indicated that the ethical group reflection and support could be one way to help staff deal with ethical issues and enhance the awareness of the complexity in the staff's everyday work in the community home services.

The result of this study may be transferable to similar contexts, but further studies are needed to ensure that. Besides, more future studies are needed to focus on the perspectives of the patients, specifically psychiatric patients, and older patients.

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Authers' contribution

The author independently contributed to the study design, datacollection, analysis and writing the result as well as the rest of the manuscript.

Conflict of interest

The author None declared.

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